ONDCP'S FISCAL YEAR 2010 NATIONAL DRUG CONTROL BUDGET AND THE PRIORITIES, OBJECTIVES, AND POLICIES OF THE OFFICE OF NATIONAL DRUG CONTROL POLICY UNDER THE NEW ADMINISTRATION

HEARING

BEFORE THE

SUBCOMMITTEE ON DOMESTIC POLICY

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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ONDCP'S FISCAL YEAR 2010 NATIONAL DRUG CONTROL BUDGET AND THE PRIORITIES, OBJECTIVES, AND POLICIES OF THE OFFICE OF NATIONAL DRUG CONTROL POLICY UNDER THE NEW ADMINISTRATION

TUESDAY, MAY 19, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON DOMESTIC POLICY,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Cummings, Watson, Kennedy, and Jordan.

Staff present: Jaron R. Bourke, staff director; Claire Coleman, counsel; Jean Gosa, clerk; Charisma Williams, staff assistant; Leneal Scott, IT specialist, full committee; Dan Blankenburg, minority director of outreach and senior advisor; Adam Fromm, minority chief clerk and Member liaison; Ashley Callen, minority counsel; and Molly Boyl, minority professional staff member.

Mr. KUCINICH. Good afternoon. The Subcommittee on Domestic Policy of the Committee on Oversight and Government Reform will now come to order. I'm pleased to be joined by our ranking member, Mr. Jordan of Ohio.

Today's hearing will examine the successes and failures of current U.S. drug policy under the Office of National Drug Control Policy, and the priorities and objectives of ONDCP under the new administration, and how those goals are reflected in the 2010 fiscal year national drug control budget.

Without objection, the Chair and the ranking minority member will have 5 minutes to make opening statements, followed by opening statements not to exceed 3 minutes by any other Member who seeks recognition. And without objection, Members and witnesses may have 5 legislative days to submit a written statement or extraneous materials for the record.

We're here today to address the policy priorities in the 2010 budget for the Office of National Drug Control Policy, which is now under the leadership of the newly confirmed Director Gil Kerlikowske. I would like to start by congratulating Mr. Kerlikowske on his confirmation. I'm extremely pleased that President Obama chose such a highly qualified individual for the job, and I truly look forward to working together.

I would also like to reaffirm the majority's commitment to Mr. Jordan that we intend to work in a bipartisan fashion in overseeing the ONDCP and its ability to create effective policy to reduce drug use and its harmful consequences.

I was pleased to read Director Kerlikowske's interview with the Wall Street Journal last week, during which he acknowledged that we need to abandon the metaphor of the Nation's, "war on drugs." Clearly the war waged since the coining of the phrase by former President Richard Nixon has failed, but we need to do more than change the label. We must also change the policy. The current national strategy, which emphasizes incarceration and interdiction to reduce drug use and its harmful consequences has clearly failed. The United States ranks first in the word in per capita incarceration rates, with 5 percent of the world's population, but 25 percent of the world's prisoners. Roughly 500,000 people are behind bars for a drug law violation, and a racial disparity in arrest and incarceration numbers, largely a result of selective enforcement and Federal mandatory minimum sentences for crack cocaine, is unacceptable. And despite these record-breaking numbers, drugs have only become cheaper, stronger and more accessible in the United States, the largest consumer of drugs in the world.

This record of failure is not tolerable and requires substantial reform. Despite promising statements by the new administration and you, Director Kerlikowske, the fiscal year 2010 budget does not reflect a changed approach to fighting drug abuse. While there's increased emphasis on treatment programs, the spending allocated to supply side initiatives still vastly outweighs the demand-side programs.

The 2010 budget actually widens the spending gap by allocating 65.6 percent of the budget to supply side initiatives and only 34.4 percent to demand-side efforts. As we will hear from our witnesses today, spending nearly $2 on supply side programs for every dollar on demand-side programs makes little sense considering the vast social scientific data showing that demand-side initiatives, especially drug treatment and prevention, are far more effective in combating drug use.

Now, I understand, Director Kerlikowske, that you've not yet been—that you were not confirmed while this budget was being developed. Perhaps it does not reflect fully yours or the new administration's intended direction under your directorship. We'll need to hear from you today on that point.

While we don't have time to evaluate every important drug policy issue here today a few warrant mentioning. First, our international supply side programs should be evaluated to ensure they're not doing more harm than good. I'm deeply concerned about the practice of aerial fumigation of coca crops in Central and South America, which is destroying the livelihoods of small farmers and is increasing the rate of rainforest destruction. Additionally, the Merida Initiative, designed to assist Mexico in its fight against drug trafficking, needs to be watched closely to ensure the United States is not fueling the violence by creating power vacuums when we help take out cartel leaders.

Second, we cannot afford to concentrate so much of our effort on youth marijuana use at the expense of addressing the needs of ad-

dicts of harder drugs who are not getting sufficient treatment under the current strategy. In 2006, nearly half of all arrests for drug law violations were for marijuana, with nearly 740,000 for possession alone. Public leaders from all over the world and across the political spectrum are starting to call for a robust debate on whether legalizing marijuana would reduce drug-related crime and provide other benefits. On May 6th of this year, California Governor Arnold Schwarzenegger stated publicly that the discussion over whether to legalize and tax marijuana for recreational use in California would benefit from a large-scale study to show the possible impact of such a change. The El Paso, TX, City Council passed a resolution earlier this year urging Congress to consider some form of decriminalization or legalization as a way to undercut organized crime.

As the Nation's leading drug policymaker, the ONDCP has an obligation to begin to study this issue. A good place to start is commissioning the National Academy of Sciences to examine available research and provide an objective overview of the risks and benefits associated with marijuana policies and marijuana use.

Third, as the new administration has now recognized, the drug problem in the United States is a public health crisis, and drug policy should reflect a desire to reduce harms associated with drug use. According to the U.S. Centers for Disease Control and Prevention, 36 percent of AIDS cases in the United States can be traced back to intravenous drug use. The ONDCP cannot afford to ignore the strong scientific consensus that needle exchange programs are effective at reducing the transmission of HIV without leading to more drug abuse.

I'm going to submit the rest of this statement of mine for the record and now go to the ranking member, Mr. Jordan, so you can get your statement in, and then we'll come back after the vote.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

Opening Statement
Of
Dennis Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee
Hearing on ONDCP Budget and Policy
Tuesday, May 19, 2009
2154 Rayburn HOB
2:00 P.M.

We are here today to address the policy priorities and 2010 Budget for the Office of National Drug Control Policy, which is now under the leadership of the newly confirmed Director, Gil Kerlikowske. I'd like to start by congratulating Mr. Kerlikowske on his confirmation – I am extremely pleased that President Obama chose such a highly qualified individual for the job, and I truly look forward to working together. I'd also like to reaffirm the Majority's commitment to Mr. Jordan that we intend to work in a bipartisan fashion in overseeing the ONDCP and its ability to create effective policy to reduce drug use and its harmful consequences.

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reflect a changed approach to fighting drug abuse. While there is an increased emphasis on treatment programs, the spending allocated to supply-side initiatives still vastly outweighs the demand-side programs. The 2010 budget actually widens the spending gap by allocating 65.6% of the budget to supply-side initiatives, and only 34.4% to demand-side efforts. As we will hear from our witnesses today, spending nearly two dollars on supply-side programs for every dollar on demand-side programs make little sense considering the vast social scientific data showing that demand side initiatives, especially drug treatment and prevention, are far more effective in combating drug use.

Now I understand, Mr. Kerlikowske, that you had not yet been confirmed while this budget was developed. Perhaps it does not reflect fully your or the new Administration's intended direction. We will need to hear from you today on that point.

While we won't have time to evaluate every important drug policy issue today, a few warrant mentioning:

First, our international supply-side programs should be reevaluated to ensure they are not doing more harm than good. I am deeply concerned about the practice of aerial fumigation of coca crops in Central and South America, which is destroying the livelihoods of small farmers and is increasing the rate of rainforest destruction. Additionally, the Merida Initiative designed to assist Mexico in its fight against drug trafficking needs to be watched closely to ensure that the U.S. is not fueling the violence by creating power vacuums when we help take out cartel leaders.

Second, we cannot afford to concentrate so much of our effort on youth marijuana use at the expense of addressing the needs of addicts of harder drugs who are not getting sufficient treatment under the current strategy. In 2006, nearly half of all arrests for drug law violations were for marijuana, with nearly 740,000 for possession alone. Public leaders from all over the world and across the political spectrum are starting to call for a robust debate on whether legalizing marijuana would reduce drug-related crime and provide other benefits. On May 6th, California Governor Arnold Schwarzenegger stated publicly that the discussion over whether to legalize and tax marijuana for recreational use in California would benefit from a large-scale study to show the possible impact of such a change. The El Paso, Texas City Council passed a

resolution earlier this year urging Congress to consider some form of decriminalization or legalization as a way to undercut organized crime. While I'm not suggesting this is the solution to our drug epidemic, as the nation's leading drug policymaker, the ONDCP has an obligation to begin to study this issue. A good place to start is commissioning the National Academy of Sciences to examine available research and provide an objective overview of the risks and benefits associated with both marijuana use and marijuana policies.

Third, as the new Administration has now recognized, the drug problem in the U.S. is a public health crisis, and drug policy should reflect a desire to reduce harms associated with drug use. According to the U.S. Centers for Disease Control and Prevention, 36% of AIDS cases in the United States can be traced back to intravenous drug use. The ONDCP cannot afford to ignore the strong scientific consensus that needle-exchange programs are effective at reducing the transmission of HIV without leading to more drug abuse. The Obama Administration had pledged to support lifting the ban on federal funding of syringe exchange, yet the 2010 Federal Budget still contains the ban. I hope that the ONDCP will work to help make lifting this ban a reality.

In addition to policy reform, we will need to discuss certain specific examples of problems this Subcommittee has noted at ONDCP in the past, and your intentions to address them.

Last year, this Subcommittee held a hearing on the ONDCP's compliance with the Reauthorization Act, and found that by and large the ONCDP had ignored mandates to change its budget reporting structure to include all drug control activity; improve its performance measurement system; and collaborate with Congress effectively through reports and meaningful dialogue. Now, I am glad to hear that the ONDCP has already begun implementing changes resulting from Congress' concerns and the Report of the National Association of Public Administrators. But the FY 2010 Budget still retains the limited budget structure that has been used since 2004, and does not incorporate new performance measures. It is our hope that the ONDCP will act speedily to come into compliance with the Reauthorization Act's requirements so that Congress will have the ability to determine which drug control policies are effective in reducing drug abuse.

The ONDCP Reauthorization Act of 2006 is set to expire at the end of 2010. The 111th Congress – and this Subcommittee in particular – will have the challenging task of ensuring that the 2010 Reauthorization reflects the direction we want this country's drug policy to go in. We are committed to working cooperatively with ONDCP to strengthen our nation's drug policy, and look forward to beginning this dialog today with new leadership in the office.

Mr. JORDAN. I'm going to thank the chairman, too, for the way he runs this committee and the way he keeps our side of the aisle informed. He does things in an honorable and professional way. And thank our witnesses for being here today and the other witnesses as well. And, frankly, Mr. Kerlikowske, thank you for your background, your service in law enforcement. We appreciate that as well.

The new administration has signaled significant shifting of our Nation's drug policy. Rather than changing the laws on the books, in my view we need robust interdiction, diligent prevention, strong law enforcement and effective treatment.

I'm troubled by Attorney General Holder's announcement that the Federal Government will no longer raid medical marijuana facilities in California. Marijuana is the drug most readily available to our youth. Reports indicate that almost any adult who enters a medical marijuana facility and complains of a headache can leave with marijuana and turn around and distribute that drug to any willing takers, including young people. Eighteen-year-old high school students can get a prescription for marijuana and have them filled at the dispensaries. It is my hope that the administration listens to the science, follows the law and uses common sense in enforcing regulations of these facilities.

It also concerns me to read articles like the one in the Wall Street Journal where newly confirmed Director Kerlikowske, our witness, called for an end to the war on drugs, the, "war on drugs." In communities across our district, I have seen the devastating effects that drugs like heroin and methamphetamines had on families and the crime that always results from this kind of drug use and drug abuse. Without proper enforcement and strengthening of existing laws, these tragedies will continue to occur. To suggest that the Government should turn its back on this issue is a failure to recognize the gravity of the situation or the right course of action.

I'm also troubled by President Obama's stance on needle exchange that he articulated during the campaign. It is no less concerning to hear the new ONDCP Director voice his support for needle exchange programs, and I look forward to hearing you talk about that, and I'll be asking questions about that, Director. However, I've noticed that in the budget advance last week, there were no funds for needle exchange. I look forward to hearing again, as I said, Director Kerlikowske explain the administration's plan for such a program.

While no doubt well intentioned, needle exchange programs do nothing but perpetuate deadly lifestyles and encourage further drug abuse. According to the Drug Free America Foundation, needle exchange program users are given clean needles, but are not required to turn in the dirty needles. The personnel of these centers refer users to rehabilitative treatment. Studies of needle exchange programs in Vancouver, British Columbia, did show—did not show, excuse me, did not show reductions in rates of HIV, hepatitis C and other infections, serious infections like MRSA. In fact, the opposite occurred; rates of infection actually rose.

To conclude, the, "war on drugs" will not succeed unless we seek to destroy the drugs where they grow, stop the drugs at the border,

and arrest those who deal and distribute drugs. We commend all of our law enforcement officers at the Drug Enforcement Agency, the Border Patrol and the Coast Guard. They play a vital role in these efforts.

On the prevention and treatment front, we need to encourage families, churches, schools and communities to educate our citizens about the dangers of drug use.

Director, I hope you will have the courage to pull the plug on programs that are not giving the taxpayers a return on their investment.

I look forward to hearing from all our witnesses on efforts we can take to stop drug abuse, prevent drug crime and make sure that the families and communities have the tools they need to stay drug free. And I want to thank you again for your willingness to serve both in your past profession and this new responsibility, and your willingness to be with us here this afternoon.

[The prepared statement of Hon. Jim Jordan follows:]

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225-5051
Minority (202) 225-5074

May 19, 2009

Statement of Rep. Jim Jordan
Ranking Republican Member
Subcommittee on Domestic Policy

"ONDCP's Fiscal Year 2010 National Drug Control Budget and the Priorities, Objectives, and Policies of the Office of National Drug Control Policy under the New Administration."

Thank you, Chairman Kucinich, for holding this hearing on the Office of National Drug Control Policy (ONDCP). I also want to thank the witnesses for taking time out of their busy schedules to testify before the Subcommittee.

The new Administration has signaled significant shifting of our Nation's drug policy. Rather than changing the laws on the books, in my view, we need robust interdiction, diligent prevention, strong law enforcement, and effective treatment.

I am troubled by Attorney General Holder's announcement that the federal government will no longer raid medical-marijuana facilities in California. Marijuana is the drug most readily available to our youth. Reports indicate that almost any adult who enters a medical-marijuana facility and complains of a headache can leave with marijuana and turn around and distribute the drug to any willing takers, including minors. Eighteen year old high school students can get prescriptions for marijuana and have them filled at the dispensaries. It is my hope that the Administration listens to the science, follows the law, and uses common sense in enforcing regulations of these facilities.

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and methamphetamines have had on families, and the crime that results from drug abuse. Without proper enforcement and strengthening of existing laws, these tragedies will continue to occur. To suggest that the government should turn its back on this issue is a failure to recognize the gravity of the situation or the right course of action.

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To conclude, The "War on Drugs" will not succeed unless we seek to destroy the drugs where they grow, stop the drugs at the border, and arrest those who deal or distribute drugs. We commend all our law enforcement officers at the Drug Enforcement Agency, the Border Patrol, and the Coast Guard. They play a vital role in these efforts. On the prevention and treatment front, we need to encourage families, churches, schools, and communities to educate our citizens about the dangers of drug use

Director Kerlikowske, I hope you will have the courage to pull the plug on programs that are not giving the taxpayers a return on their investment. I look forward to hearing from all of our witnesses on efforts we can take to stop drug abuse, prevent drug crime, and make sure that families and communities have the tools they need to stay drug free.

Thank you all for coming.

Mr. JORDAN. And I guess we're going to go vote; is that right, Mr. Chairman?

Mr. KUCINICH. Thank you very much, Mr. Jordan. The committee is going to recess for the vote.

I've been informed by staff that we have three votes. My best guess is that we'll be back here in about a half hour. So let's resume at quarter to 3. Thank you for being here. And at that point we'll get into your testimony, Mr. Kerlikowske. Thanks to everyone here.

[Recess.]

Mr. KUCINICH. Mr. Kerlikowske, it's the policy of the Government Oversight and Reform Committee to swear in witnesses, so if you would please rise.

[Witness sworn.]

Mr. KUCINICH. Let the record reflect that the gentleman answered in the affirmative.

All witnesses will have 5 minutes to make their statement. Your entire statement will be included in the record. So if you just want to give us highlights or whatever, that would be fine. And we are grateful for your presence here. You may proceed, sir.

STATEMENT OF GIL KERLIKOWSKE, DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY

Mr. KERLIKOWSKE. Thank you, Mr. Chairman. With only 8 days on the job, I think the highlights——

Mr. KUCINICH. Is that mic on, staff?

Hold on.

Mr. KERLIKOWSKE. With only 8 days on the job, I think highlights will be about all I could provide at this point. But, Chairman Kucinich, Ranking Member Jordan, distinguished members of the subcommittee, thank you for providing me an opportunity to appear before you today. And I believe very strongly in the benefits of collaboration and transparency and accountability. As chief of police for 9 years in Seattle, I enlisted that, the support of the entire community, to reduce crime. This approach in Seattle led to the lowest drug use and the serious crime rates in decline since 1967.

I plan to employ a similar approach in my leadership of ONDCP, and I'll be guided by these principles in the development, articulation and implementation of an effective, comprehensive and coordinated national drug control strategy, but I will certainly need help. And I will rely upon Congress to provide its perspectives as we develop these policies.

Thousands of Americans lose their lives each year because of illicit drug use. I am deeply troubled by the recent sharp increases in drug-related deaths. In the latest year for which drug data are available, 2006, overdose deaths surpassed gunshot wounds, and they now rank second only to motor vehicle accidents as a cause of accidental death in our country.

Reducing fatal drug overdoses, particularly deaths involving controlled prescription drugs, is an urgent challenge. We know that the abuse and addiction are in the background of many other negative social consequences. There is no single approach. Prevention, treatment, enforcement and interdiction must all be priorities, and

they are not mutually exclusive. This administration's approach to drug control will be comprehensive, and it will be evidence-based.

Now, there's a perennial argument in this town over the drug control budget, and I think fresh thinking is required. That's why in my first week on the job I hosted meetings with experts in the prevention field representing both government and nongovernmental organizations to look at a fresh perspective on the United States' approach to prevention. These meetings will continue and will result in concrete proposals supported by data.

I'm proud of the work of ONDCP's media campaign, and I know that the Drug-Free Communities program is an excellent investment, but it's time also to unearth the next great set of ideas in the field of prevention.

The fiscal year 2010 budget summary that was delivered to you last week is focused on four major policy areas: substance abuse prevention, substance abuse treatment, domestic law enforcement and interdiction, and international counterdrug support, and it lays the foundation from which we will build. I have provided you greater detail about this budget in both my written testimony and also in the fiscal year 2010 budget summary that our staff shared with you last week. I'm sure we'll discuss this budget momentarily in great detail.

I'm also sure that we'll discuss the National Academy of Public Administration Report that was recently released. I found the report to be thoughtful and productive for the most part. In my written testimony I provided details on the steps we are taking to address most of the recommendations in the report. But with respect to the recommendation concerning the office's budget oversight responsibilities, I have concerns. The use of such a process would be a detriment—would be detrimental to reducing the Nation's drug control efforts.

In my view, Congress envisioned the Director of the National Drug Control Policy as a strong advocate for drug control funding. By the nature of this role, I am tasked with taking a proactive view toward drug control policy. Without ONDCP's current budget authorities, my ability to influence the outcome of critical resourcing decisions would be limited. I came to Washington, Mr. Chairman, to be the champion of intelligent and far-reaching drug policies. Adherence to this recommendation would handcuff me and those who succeed me.

In 9 months we'll deliver the 2010 National Drug Control Strategy and the supporting fiscal year 2011 budget, which focus on the nature and the scope of the problems, as well as the policies and programs which will have the most meaningful impact. During my tenure we will focus on developing systems to monitor the progress we are making in our drug control efforts. We will be transparent about our progress; we will let evidence guide our policies. Importantly, we will be alert to new and emerging drug threats and provide leadership to address them as they arise.

I also believe that if you can't measure it, you can't improve it; therefore, we must establish in short order 2- and 5-year performance measures and targets for each strategy goal, reducing drug use, availability and consequences. The performance management

system currently in place begins to assess the effectiveness of interagency efforts, but it is not comprehensive or systemic.

ONDCP will assist in building a more fair and equitable criminal justice system by improving and increasing services for offenders with substance abuse disorders, including diversion programs such as drug court treatment services within correctional facilities and reentry programs. I will also work to improve collaboration between State and local law enforcement and Federal agencies. This will improve our ability to reduce trafficking in illicit drugs. State and local law enforcement have knowledge which needs to be communicated to local agencies to support their efforts. Task forces such as those supported by HIDTA——

Mr. KUCINICH. The gentleman's time is expired, but what we'll do is permit you time to wrap it up.

Mr. KERLIKOWSKE. Likewise, Federal agencies can do a better job. I want you to know, Mr. Chairman, that I appreciate this opportunity to come here early in my tenure, and I look forward to working with all of the members of the subcommittee as we move forward. Thank you.

Mr. KUCINICH. Thank you very much, sir.

[The prepared statement of Mr. Kerlikowske follows:]

Testimony

Of

Gil Kerlikowske

Director

National Drug Control Policy

Domestic Policy Subcommittee

Oversight and Government Reform Committee

ONDCP's Fiscal Year 2010 National Drug Control Budget and the Priorities, Objectives, and Policies of the Office of National Drug Control Policy under the New Administration

Tuesday, May 19, 2009

2154 Rayburn HOB

2:00 p.m.

Chairman Kucinich, Ranking Member Jordan, distinguished members of the Subcommittee, thank you for providing the Office of National Drug Control (ONDCP) the opportunity to appear before you today to share our views on the Fiscal Year 2010 National Drug Control Budget and Priorities. I am new to this position, and am pleased to have this opportunity early in my tenure. I hope this is the first of many opportunities I will have to testify before you.

This testimony provides an overview of the authorities Congress vests in my position and ONDCP, the goals Congress established for ONDCP, and describes the actions already taken by this Administration to meet your expectations. First, I will describe our response to one of the major recommendations ONDCP received from an independent panel of the National Academy of Public Administration (NAPA). I will start the testimony by describing the response to this recommendation, because this forms the basis of the entire policy, budget, and strategy development process which I oversee. I will then move to issues of performance management, the FY 2010 Budget, and finally, to the remaining NAPA recommendations.

The Obama Administration understands addiction is a disease, and its treatment needs to be addressed as part of a comprehensive strategy to stop drug use.. Research shows addiction is a complex, biological, and psychological disorder. It is progressive and chronic, and negatively affects individuals, families, communities, and society. In 2007, over 20 million individuals in our country (12 and older) were diagnosed with substance dependence or abuse. However, less than 10% received treatment for their disorder[1].

Treatment is effective. Three decades of scientific research and clinical practice have yielded a variety of effective approaches to drug addiction treatment. Extensive data document drug addiction treatment is as effective as is treatment for most other similarly chronic medical conditions such as diabetes, hypertension, and asthma.

[1] Results from the 2007 National Survey on Drug Use and Health: National Findings, Substance Abuse and Mental Health Services Administration (SAMHSA), 2008, http://www.oas.samhsa.gov/nsduh/atest.htm

Essential to my efforts is restoration of the vitality of ONDCP by recommitting the agency to its policy leadership mission. ONDCP was created by the Congress to focus this Nation's efforts toward resolving the drug problem by developing and implementing a balanced, comprehensive National Drug Control Strategy. ONDCP will effectively build consensus on how best to use interdiction efforts, law enforcement, treatment, prevention, and sound research to achieve measurable results in reducing drug use and its consequences. During my tenure, debate will be continuous and inclusive of disparate ideas. Deliberation will be comprehensive and collaborative.

As you are well aware, it is the responsibility of ONDCP to assist the President in the establishment of policies, goals, objectives, and priorities for the National Drug Control Program and to promulgate the National Drug Control Strategy. Already since the transition to the new Administration, major strides have been made toward ensuring that we effectively carry out these important authorities.

NAPA indicated in their report that ONDCP must develop a more comprehensive multi-year National Drug Control Strategy, informed by a variety of data, as well as build a collaborative and consultative environment to increase our effectiveness. I could not agree more.

In response to this recommendation, ONDCP instituted a new process which fully integrates, for the first time, policy, budget development, and outreach. This process will ultimately provide greater internal collaboration among the office components and our inter-agency partners, as well as aid development of the President's National Drug Control Strategy and Budget. The policy and budget development and outreach plan brings together the comprehensive skill sets required to develop the Strategy and more fully capitalizes on the staff's expertise in the formulation of the FY 2011 Budget. We established a Policy/Budget Steering Group, and four Policy/Budget Working Groups representing prevention, treatment, domestic law enforcement, and interdiction and international counterdrug support.

The Policy/Budget Steering Group oversees the Strategy and Budget development process and inter-agency outreach efforts, and provides direction to the four Working Groups. The group

is chaired by the ONDCP Chief of Staff and meets monthly. The group also meets regularly with Departments to solicit their views, ensure policy coordination, and discuss relevant performance issues.

The Working Groups are responsible for managing policy and budget development from inception to completion. These include policy and budget development, budget execution, performance assessment, and outreach/liaison efforts.

Additionally, the Panel recommended that ONDCP establish a working group of subject matter experts to advise ONDCP senior leadership on international, national, and regional/local drug issues. We have recently re-established the Drug Demand Reduction Interagency Working Group. The first meeting was on April 1, 2009 at the White House Conference Center. Approximately 60 individuals representing nearly 30 different agencies attended. Thanks to the Acting Director during the political transition, Ed Jurith, six working groups were developed:

- Military, Veterans, and their Families
- Justice Systems
- Prevention and Education
- Emerging Threats
- Healthcare Delivery
- Performance, Accountability, and Effectiveness

There is an important connection between the external and internal groups. The internal groups are poised to use the information they receive from the external groups to develop policy which will ultimately drive the National Drug Control Strategy and Budget.

In the international arena, ONDCP participates in the Southwest Border-Merida Initiative Interagency Policy Committee and associated Deputy Committee meetings, which address all policy issues concerning domestic Southwest Border issues and the Merida Initiative implementation for Mexico, Central America, and Hispaniola. As well, ONDCP continues to oversee and participate in the interagency working groups that are developing the National Southwest Border Counternarcotics Strategy. These working groups were assembled by the

Department of Homeland Security, Office of Counternarcotics Enforcement, and the Department of Justice, Office of the Deputy Attorney General, in their roles as the designated Executive Agents for the strategy's development. These interagency working groups will continue to support the strategy's implementation in the months ahead. ONDCP also co-chairs, along with the Department of State's Bureau of International Narcotics and Law Enforcement Affairs, the Afghanistan Counternarcotics Working Group, which addresses all counternarcotics policy and implementation issues for Afghanistan.

In the 2006 ONDCP Reauthorization Act, Congress called for an update of the Southwest Border Counternarcotics Strategy every two years. The most current version of this document has undergone an accelerated review and update since the start of the new Administration. The current draft, which will be released in the near future, includes a chapter on weapons, a new chapter on technology, new language on drugs and gangs, and a detailed annex. The 2009 Southwest Border Counternarcotics Strategy also incorporates many of the recent personnel, technology, and infrastructure initiatives being planned or carried out by DHS, DOJ, and other drug control agencies, to intensify our national efforts to combat both the northbound flow of drugs and the southbound flow of bulk currency and weapons. We believe this Strategy, the Merida Initiative led by the Department of State, and other contingency planning and bilateral engagement efforts by DHS, DOJ and others will enable the United States and our partners in Mexico to significantly reduce the threat posed by Mexican drug cartels to law abiding citizens on both sides of the border.

ONDCP has also instituted a Steering Group for Counterdrug Technology which will assist in identifying counterdrug mission-related research efforts and work with the appropriate technical personnel within each of the Steering Group member agencies, which can help coordinate project ideas for research. We will be considering research in the areas of reducing the misuse of prescription drugs and reducing drug trafficking through the Southwest Border. We believe these are important areas that require further emphasis in research. The first meeting was held last week.

With regards to performance measurement, the current system begins to assess the effectiveness of the interagency process in implementing the President's National Drug Control Strategy, but it is not comprehensive or systemic. It utilizes several mechanisms to assess departmental program contributions: the annual budget certification process, the Budget Summary, agency Performance Summary Reports, and technical assistance from ONDCP.

While this system provides an assessment of individual program performance, it does not provide an assessment of interagency progress towards the Strategy's policy goals. When Congress reauthorized ONDCP in 2006, a provision was enacted that required ONDCP to establish two and five-year performance measures and targets for each Strategy goal—reducing drug use, availability, and consequences.

As we begin developing President Obama's first National Drug Control Strategy, I will work collaboratively with my Federal, state, tribal, and local partners to develop a comprehensive Strategy, guided by sound principles of public safety and public health. We will set aggressive policy goals to reduce youth and adult drug use, limit drug availability in the Nation, and mitigate the difficult and costly consequences associated with drug use. When Congress created ONDCP, the intent was to establish an organization that would utilize data to formulate effective policies. I intend to fulfill that commitment by reviewing the research and establishing a more comprehensive interagency performance measurement system. Further, I intend to utilize the reconstituted interagency working groups to develop joint policy targets which reflect our common goals regarding use, availability, and consequences. This new performance system will also enable us to assess the contributions of individual drug control agencies towards these joint targets.

As we move forward, we will conduct a thorough examination of the drug control budget. As the President's representative on drug control policy, my office has the key task of working with interagency partners, outside experts, and collaborating with key Members of Congress on the structure of the Budget. I envision a drug control budget which provides a comprehensive accounting of key Federal drug control resources. Additionally, we intend to fully integrate policy and budget development to ensure policy drives the budget process.

All of these processes assist our development of a comprehensive and research-based National Drug Control Strategy, Budget, and policies. It is my philosophy that this Administration cannot develop a comprehensive Strategy until these processes yield meaningful data for analysis. The Strategy and the Budget will reflect trends and needs, based on analysis of data and consultation with partners and other experts. In nine months, we will deliver a National Drug Control Strategy and Budget that focuses on the nature and scope of the problems as well as the policies and programs that will have the most meaningful impact.

The FY 2010 Budget that was delivered to you last week lays the foundation from which we will build. For example, the budget includes significant treatment and recovery support services for those individuals who come into contact with the criminal justice system, supports research-based prevention efforts, addresses violence associated with narcotics trafficking along the Southwest border area, and continues to support Mexico's efforts to address the drug problem.

The Drug Control Budget is focused on four major policy areas: (1) Substance Abuse Prevention, (2) Substance Abuse Treatment, (3) Domestic Law Enforcement; and (4) Interdiction and International Counterdrug Support. For Fiscal Year 2010, we have requested $15.1 billion in support of these key policy areas, which is an increase of $224.3 million, or 1.5 percent, over the FY 2009 enacted level of $14.8 billion.

For substance abuse prevention programs, the President's budget requests resources totaling $1.6 billion, which will support a variety of research, education and outreach programs aimed at preventing the initiation of drug use. The prevention budget request in FY 2010 includes $100.0 million for a new initiative, Improving School Culture and Climate, to support new approaches to assisting schools in fostering a safe, secure, and drug-free learning environment, particularly by using approaches designed to change school culture and climate. The budget continues to fund the Drug-Free Communities (DFC) program ($90.0 million) and the National Youth Anti-Drug Media Campaign (Media Campaign) ($70.0 million) at the FY 2009 enacted levels. The DFC program provides grant funding to over 750 local drug-free coalitions to develop plans that combat youth substance abuse problems. The Media Campaign utilizes media channels to

educate and motivate youth to develop anti-drug beliefs and behaviors, and empowers adults to keep youth drug-free.

There continues to be much discussion in the media about whether "personal use" of drugs should be decriminalized. What we cannot lose sight of during this discussion, is that we all agree addiction is a preventable and treatable chronic condition. The Budget dedicates more than $3.6 billion in Federal funds to drug treatment and intervention efforts in FY 2010, representing an increase of $150.1 million over the FY 2009 level. U.S. supported research has contributed to major advances in drug treatment. Key discoveries about the safety and efficacy of medications, such as buprenorphine, to treat opiate addiction, have helped thousands of heroin users reduce the urge to use opiates. Recovery from methamphetamine addiction was once thought to be impossible. Now, the promise of healing has brought new-found hope to individuals, families, and communities across this Nation.

Therefore, the FY 2010 Budget includes numerous requests in the HHS portion of the Budget, including a request of $29.1 million for Screening, Brief Intervention, and Referral to Treatment (SBIRT). The SBIRT grant program uses cooperative agreements to expand and enhance a state or Tribal organization's continuum of care by adding screening, brief intervention and treatment services within general medical settings. Further, HHS actuaries estimate $240.0 million in FY 2010 Medicaid spending for States that will have adopted two Healthcare Common Procedure Coding System (HCPCS) codes that the Centers for Medicare & Medicaid Services developed for alcohol & drug screening and brief intervention. Further expanding this valuable tool to a range of medical settings will enable clinicians to screen more patients for substance abuse disorders, prevent use and treat individuals, and ultimately reduce the burden of addictive disorders on the Nation, communities, and families. The National Institute on Drug Abuse has also recently launched NIDAMED - a new initiative providing research-based screening tools and resources to help broaden screening for drug use in medical settings.

Additionally, $99.0 million is requested for the Access to Recovery Program (ATR), which seeks to expand access to substance abuse treatment and recovery support services, including

those provided by community and faith-based organizations. ATR allows individuals to tailor treatment services to best meet their needs, such as including services focused on methamphetamine treatment and those which support sustained recovery, like child-care, employment training, and housing.

Unfortunately, those who are addicted to drugs often interface with the criminal justice system, either primarily or secondarily, due to their addiction. This must be treated as an opportunity. Addressing drug abuse at every point in the criminal/juvenile justice spectrum—beginning with law enforcement, through adjudication, into correctional facilities, and back into communities through the re-entry process—is imperative to breaking the cycle of substance abuse and associated criminal behavior. With nearly 50 percent of jail and prison inmates meeting clinical criteria for abuse or addiction[2], the justice system can play a significant role not only in protecting citizens from crime, but also in reducing substance abuse through the expansion of drug courts and other problem-solving courts, re-entry programs, and treatment programs within correctional facilities.

In the HHS account, the FY 2010 Budget seeks $58.9 million for the Adult, Juvenile, and Family Drug Courts program, $23.2 million for Prisoner Re-entry, and $95.4 million for Alcohol and Substance Abuse on or near reservations to the Indian Health Service (IHS) programs to support Community Rehabilitation and Aftercare, Regional Treatment Centers, and prevention and treatment of methamphetamine abuse.

In the Department of Justice account, the budget provides $59.0 million for Drug, Mental Health and Problem-Solving Courts Program, $30 million for the Second Chance Act, and $30 million for Residential Substance Abuse Treatment. According to the Bureau of Justice Statistics, more than 700,000 prisoners leave our state and Federal prisons each year.[3] It is imperative that we support prisoners in their recovery upon release by ensuring they have access

[2] Karberg & James (2005). Substance dependence, abuse, and treatment of jail inmates, 2002. Washington, DC: Bureau of Justice Statistics, U.S. Dept. of Justice; Fazel et al. (2006). Substance abuse and dependence in prisoners: A systematic review. Addiction, 101, 181-191.

[3] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, (2008). Prison inmates at midyear 2007. Bulletin June 2008, p.4.

to recovery support services such as counseling, job training, and continued drug treatment so they are successfully reintegrated into society.

Drug Courts have demonstrated their effectiveness in reducing criminal recidivism rates. Researchers have found that drug courts reduce recidivism among target populations and among program participants, in contrast to comparable probationers. Across various studies, reductions in recidivism have ranged from 17 percent to 26 percent.

The Second Chance Act, passed in the last Congress, shifts priority from policing those on parole to more effectively rehabilitating them. The parole system has a greater obligation to help Federal offenders successfully re-enter society. Re-entry programs mentioned in the Act include treatment, job training, employment assistance, life skills training, and other services leading to successful parole and avoiding a recurrence of crime and drug abuse.

Research indicates that re-entry programs improve recidivism rates and encourage an offender's sustained recovery from illicit drug abuse. According to the Center for Drug and Alcohol Studies at the University of Delaware, participation in work-release Therapeutic Communities during the transitional period between prison and re-entry into the community have a substantial impact on the timing, incidence, and duration of subsequent drug use. In fact, the proportion of those treated who remain abstinent is approximately three times that for those without treatment.

Nearly $3.7 billion in Federal resources support critical domestic law enforcement efforts in FY 2010, an increase of $83.3 million over the FY 2009 level. The Departments of Justice, Homeland Security, and Treasury, with support from the Department of Defense's National Guard, provide key law enforcement and support to state and local law enforcement agencies. The budget includes over $67 million in enhanced funding for the Departments of Justice and Homeland Security to combat drug trafficking on the Southwest border (SWB). Narcotics smuggling in the SWB region is a significant vulnerability to U.S. security which requires increased national-level attention and unity of effort. To enhance national security, protect the American people, the economy, and our way of life from the corrosive effects of illegal drug

smuggling across the Southwest border, the Administration is fully engaged to ensure coordination and facilitation of U.S. Government counterdrug and border security initiatives. We will achieve a comprehensive national effort involving Federal, state, tribal, local, and private sector entities.

Finally, over $6.1 billion in Federal resources support programs to disrupt the flow of illicit drugs into the United States, and provide crucial support to partner nations such as Afghanistan, Mexico, and Colombia. This represents an increase of $180.6 million over the FY 2009 level, which includes an additional $109.2 million for Department of State support for Mexico, including Merida Initiative funding. The Department of Homeland Security and the Department of Justice provide the necessary assets and personnel to interdict drugs along the Nation's borders, while the efforts of the Department of Justice to suppress and prevent the flow of drugs from ever reaching our borders continues. The Department of Justice's Drug Flow Attack Strategy targets drug source and transit zones, where seizures are frequently measured in ton quantities, in addition to utilizing intelligence resources, i.e., the El Paso Intelligence Center to provide a forward defense at arrival zones. These drug control efforts are complemented by detection and monitoring efforts of the Department of Defense and partner nation support, eradication, and alternative development programs sponsored by the Department of State.

Apart from the current Budget and future Budgets and Strategies, I am pleased to share with you a number of actions ONDCP has recently undertaken to address the recommendations received in the FY 2008 study completed by an independent panel of the NAPA. Specifically, NAPA was contracted by ONDCP to gain "insights into changes and improvements that could make ONDCP more effective in the future."

Earlier in my testimony, I outlined what we are doing to address NAPA's recommendation that ONDCP develop a comprehensive multi-year National Drug Control Strategy, informed by a variety of data, as well as build a collaborative and consultative environment to increase our effectiveness. NAPA also recommended that ONDCP streamline its organizational culture; rebalance its workforce; implement effective human capital policies and practices; increase

transparency; and increase employee engagement. ONDCP has undertaken a number of steps to address these recommendations.

NAPA commented on the declining racial/ethnic diversity and female representation within ONDCP. To address this concern, ONDCP has implemented new initiatives underscoring its continuing commitment to equal opportunity, including posting and sending vacancy announcements to approximately 100 agencies, schools, and groups listed in ONDCP's Diversity Referral Database. ONDCP continues to progress in all facets of hiring.

NAPA recommended that there should be no political questions included on the student intern applications. To respond to this recommendation, ONDCP has returned to the process of an agency-specific Internship Program. There are no longer questions in the application process regarding political experience or voting. The questions are specifically tailored to working at ONDCP.

NAPA recommended creating a term limit for membership in the Senior Executive Service Performance Review Board. ONDCP has established new membership on the Performance Review Board with term limits of one year. As prescribed by regulation, members were announced in the Federal Register on March 20, 2009.

I am considering NAPA's recommendations and action items concerning the office's budget oversight responsibilities; however, I have concerns. The recommendations concerning ONDCP's budget oversight functions included action items which indicate ONDCP should no longer review and certify departmental/bureau budgets, or prepare annual accounting and performance reports, but should rely on the Office of Management and Budget (OMB) during the budget review process to ensure its funding priorities are considered.

Under the process proposed by NAPA, ONDCP would not issue funding guidance to Departments and Bureaus in the spring, but would issue joint funding guidance with OMB prior to department budget submissions in September of each year. In addition, the summer budget review (which provides Departments/Bureaus with an evaluation of how their submission

corresponds to the budget guidance), the certification of the fall budget submissions (to ensure their adequacy), and the preparation and submission to Congress of the annual accounting and performance summary reports would all be eliminated. NAPA believes such a process would "be a more efficient way for ONDCP to get the requisite funding included to support high-priority" initiatives. However, such a process is inconsistent with the statutory requirements as outlined in 21 USC §1703 (c).

While worth further study, it is my perspective that the use of such a process would be detrimental to the resourcing of the Nation's drug control efforts. Congress, in creating ONDCP, envisioned the Director of National Drug Control Policy as a strong advocate for drug control funding. By the nature of this role, I am tasked with taking a proactive view towards drug control policy. Many Federal agencies involved in drug control activities are responsible for multi-mission operations (i.e., drug and non-drug operations). Due to competing requirements throughout the year, agencies must make resource allocation decisions which affect drug control programs. Without ONDCP's budget authorities, my ability to influence the outcome of critical resourcing decisions affecting the President's National Drug Control Strategy could be limited.

The NAPA report finds it disappointing that ONDCP has used its decertification authority only once. In actuality, this highlights the success that ONDCP has had with its summer budget review and fall certification process in identifying and advocating key priorities. ONDCP's oversight of Department and Bureau budgets afford ONDCP the opportunity to get priorities placed into the budget early on in the process. It is much harder to get priorities funded during the final stages of budget development. However, through ONDCP's annual budget guidance and summer and fall budget reviews, priorities are more likely to be funded.

The NAPA report questions the utility of the annual accounting and performance reports. These reports have proven useful to ensure that agency accounting systems of records are properly reporting drug control resources, and that funds were spent in accordance with Presidential priorities and direction.

It is early in the Administration, and I have an important job to accomplish. Drug use and

addiction destroy individuals, families, and communities. I commit to you today that I will work to deliver to you a balanced and comprehensive Strategy and that I will develop drug policy which is:

- Based upon the best possible understanding of the drug threat, and incorporates a science-based approach to public policy;
- Vigorously implemented through development of a national drug budget which contains proven, effective programs; and
- Rigorously assessed and adapted to changing circumstances.

The Administration believes, even before the development of a Strategy is complete, that there are some specific areas where attention should be paid, and progress can be made in reducing use and dependence, lowering availability, and positively impacting the negative consequences associated with drug use.

It is only through a balanced approach – combining tough, but fair, enforcement with robust prevention and treatment efforts – that we will be successful in stemming both the demand and supply of illegal drugs in our country. Measurable and sustained progress against drug abuse can be made only when the efforts of local communities, state agencies, and the Federal government are coordinated and complementary. If we are to succeed, the natural silos between the prevention, treatment, and law enforcement communities must be broken down – and the greatest use must be made of the finite resources at our disposal.

I will work diligently to ensure our efforts are supported by a Federal drug control budget which logically implements research-based programs to support and implement our Strategy. There will be a renewed focus on evidence-based approaches to reduce demand for drugs, through prevention as well as treatment. Additionally, we must also work to create strong partnerships to reduce the overall impact of drug trafficking and use.

Our Nation's demand for drugs fuels drug production and trafficking, as well as violence and corruption, within other nations. Domestic drug use is a significant factor in the terrible drug-related crime currently wracking Mexico and fuels illegal armed groups in Colombia. Our

international drug control programs help strengthen law enforcement and judicial institutions.

While these international supply reduction programs play a vital role in improving security, supporting the rule of law, and denying terrorist and criminal safe havens around the world, the greatest contribution we can make toward stability is to reduce our demand for illicit drugs.

I know that you will remain engaged in the work of ONDCP as we build solid, forward-looking strategies, budgets, and policies. I look forward to meeting with each of you to establish a working relationship. We have the greatest chance of success if Congress and ONDCP are communicating openly, and working on these issues together. I look forward to answering any questions the Committee may have.

Mr. KUCINICH. I would like to begin with the questions. Mr. Kerlikowske, can you elaborate on your comments to the Wall Street Journal that we should move away from the term "war on drugs" and discuss how you might prefer to describe efforts by law enforcement and others to prevent illicit drug use?

Mr. KERLIKOWSKE. Mr. Chairman, the words matter. When we talk about a war, we talk about wars on people. War limits the tools that we have. Most people look at war as being a war using the only tool is force. Someone once told me when the only tool in the toolbox is a hammer, every problem starts looking like a nail.

I want to look at a more balanced approach. I know that my colleagues around the country, after my nomination was made by President Obama, have called me saying that they want to change the conversation. Not that enforcement and interdiction and source-country eradication are not important, but we need a more balanced, a more comprehensive, a more holistic approach.

Mr. KUCINICH. Now, numerous articles on your nomination as drug czar pointed out that in 2003, Seattle voters approved a measure making marijuana possession cases the lowest law enforcement priority. You opposed the measure at the time, yet said marijuana possession was already a low priority for Seattle Police. According to news reports, you abided by the prioritization law that Seattle voters approved.

Did the initiative have any impact on violent crime or overall public safety one way or the other, or did it make a difference? And the second part of the question, do you agree with Governor Schwarzenegger that it's time for an evidence-based study to examine available research and provide an objective overview of the risks and benefits associated with marijuana policies?

Mr. KERLIKOWSKE. In answer to the first question, Mr. Chairman, the initiative had no impact on the criminal justice——

Mr. KUCINICH. Could you put that mic a little bit closer?

Mr. KERLIKOWSKE. The initiative had no impact on the operations of the police department, nor on the operations of the criminal justice system. Personal possession of small amounts of marijuana by an adult in any large city police department, in fact, in most law enforcement agencies that I know of, is not a high priority. We figure out with finite resources, still wearing my police chief hat after 36 years, how to utilize officers and detectives in the best way possible to reduce violent crime, and we have priorities. So the initiative had no impact.

I do not agree with Governor Schwarzenegger that it is time for a discussion on legalization. I do agree that approaching this problem from a public health, a sociological standpoint; a prevention, a treatment and an enforcement standpoint in a more balanced way does make sense.

Mr. KUCINICH. Well, if you talk about legalization, according to your own testimony here, in Seattle you had a de facto decriminalization by making it the lowest priority.

Mr. KERLIKOWSKE. No. We made arrests for marijuana. People were arrested. Actually several hundred people were arrested. What we're talking about here is how do you use finite resources, prosecutorial or police officers, in order to have the most effect on keeping people safe and protecting their property. Adults who pos-

sess a small amount of marijuana who are not trafficking or dealing is not a high priority for those finite resources.

Mr. KUCINICH. But what about the Obama administration's decision with respect to DEA enforcement at medical marijuana clinics in places such as California?

Mr. KERLIKOWSKE. The point I would tell you that I have not had an opportunity to sit down with the Attorney General Eric Holder. I have only read in some press report——

Mr. KUCINICH. Well, what's your position?

Mr. KERLIKOWSKE. What was said on the Drug Enforcement Administration enforcing those laws? The DEA also, I know, has finite resources. They go after the largest traffickers and the most violent traffickers. I do not think that the medical marijuana industry fits right now in that standpoint. It doesn't mean that they don't violate the law.

Mr. KUCINICH. OK. I'm going to go to questions from Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman.

Again, Mr. Kerlikowske, thank you for being here today and for your willingness to serve and the years of service you've given the various communities as a law enforcement officer.

I want to go to that same article that the chairman referenced, the Wall Street Journal article from last week. And I'm going to start with what they reported. And I understand that when you're reading from a news account, you don't always get the truth, so you'll get a chance to elaborate. But the Executive Director of the FOP, James Pasco, the largest law enforcement labor organization in the country, said that while he holds you in high regard, he said, police officers are wary of some of the things that have been attributed to you and to the new administration in this whole context of more focus on treatment, less focus on putting people who violate the law, the consequences of doing that and going after them, and he's quoted as saying, while I don't necessarily disagree with Gil's focus on treatment and demand reduction, I don't want to see it at the expense of law enforcement. People need to understand that when they violate the law, there are consequences.

The article also points out that this administration, it says, is likely to deal with drugs as a matter of public health rather than criminal justice alone. Again, elaborate, and elaborate in the context of this, in light of what's going on on the Mexico border, what we're seeing, the violence there associated with drugs; elaborate on this kind of change in concept, or change in philosophy at least, that is articulated here and based on your answer to the chairman's kind of same line of questioning.

Mr. KERLIKOWSKE. Mr. Jordan, I go back and I would say that it's not an either/or proposition. And I couldn't agree more with Jim Pasco and the statement he made on behalf of the Fraternal Order of Police. You don't have to deemphasize or defund law enforcement in order to put further resources into treatment.

Mr. JORDAN. You say that you agree with his statement, but remember, he said police officers are wary of the very thing we just described in your position. So you can't agree with his statement when he says, we're nervous about this change in philosophy with a greater focus on, quote, treatment and not on putting the bad guys behind bars.

Mr. KERLIKOWSKE. Over many years of experience, I would tell you that every time there was a change in emphasis, law enforcement agencies who receive certain Federal funds would be concerned. There were a number of times in the previous administration that local law enforcement grants, etc., were either zeroed out or eliminated.

What I would like to say is this is about being balanced, and about using the best tools, and about leveraging those finite resources together in a smart way.

I would also say in reading the background in the last administration, this issue was also treated as a public health issue as much as a criminal justice issue.

Mr. JORDAN. Let me ask this when you're talking about public health. The President's stated position on the needle exchange concept, and talk about that, where you are personally on that issue, and do it in light of—I think if I heard your testimony right, you said overdose deaths surpass gun deaths, surpass everything except, if I caught it right, traffic—I mean, car accidents. So talk about where you are on this needle exchange idea.

Mr. KERLIKOWSKE. Those overdose deaths are primarily due to pharmaceutical—the abuse of pharmaceuticals.

In answer to the question on the needle exchanges, it is seen as part of an overall public health issue. In the two cities where I've been, two large cities where I've been chief of police and we have had needle exchanges, they were not a law enforcement problem. And, in fact, the needle exchange in Buffalo actually took calls from neighbors and would clean up any needles that were disposed of inappropriately in some other place.

Mr. JORDAN. How about the data I cited in my opening statement about where you see increased infection rates, increased HIV, increased hepatitis where you have needle exchange programs?

Mr. KERLIKOWSKE. Mr. Jordan, I'm actually not familiar with the data from Vancouver, British Columbia, but I would be happy to examine it in greater detail and respond back to you.

Mr. JORDAN. OK. I got 30 seconds. Let me ask one other thing. How does your office—this is a practical question. I don't know, and short of research, how do you interface with Homeland Security specifically, thinking about what's going on on the southern border of our country; how do you at all, if at all, interface with Homeland Security?

Mr. KERLIKOWSKE. I know that a meeting is being scheduled very quickly with Secretary Napolitano and myself. I had a chance to speak with her. She's looking forward to asking ONDCP to be a part of this initiative. And frankly, we have that statutory role and authority to do that, and now that I'm in place, I'll work with her.

Mr. JORDAN. But I guess I'm asking, what's been the history of the organization you now head interfacing with Homeland Security? Do you know that? Can you give that to me?

Mr. KERLIKOWSKE. I don't know, Mr. Jordan.

Mr. JORDAN. OK. We'll research it.

Thank you, Mr. Chairman.

Mr. KUCINICH. Thank you.

The Chair recognizes Mr. Kennedy.

Mr. KENNEDY. Thank you.

Welcome. I appreciate the Wall Street Journal article and what message you've sent at the outset of your tenure as drug czar. And I just want to take today's paper, May 19th, we're in today, my local newspaper in Rhode Island, as an example of why what you said is so important.

The front page: Man is Killed, Officer Shot Within 30 Minutes. More on this case, B4. You go to B4: Shooting Suspect Possessed Lengthy Criminal Record. Driving while impaired in 1998, attempted breaking and entry. I'm sure that had nothing to do with him trying to supply himself with drugs. Then in 2002, undergoes substance abuse counseling, receiving stolen goods. I'm sure that had nothing to do with his addiction again. 2003, violated and suspended sentence for drugs. 2004, suspended sentence, substance abuse counseling. 2005, 1-year suspended sentence, substance abuse counseling, domestic vandalism and assault.

So here's one. That's just one story. That's the front page.

The second front-page story is: Teen Facing Prison Over Boat Fatality. Teenager accused of striking and killing his friend on a boat in the Barrington River in 2007 took responsibility for his role in the death yesterday, Monday, in Superior Court. While boating, the 17-year old took responsibility for the death of Patrick Murphy after a day of boating with other teens on the river July 17, 2007. He faces over 5 years in prison.

Then you turn to the local Metro section of the Rhode Island: Plea Deal Likely in Drunk Driving Case. David Hazard faces three felony counts in connection with April 7th accident, Route 12 situate that killed Foster woman. Killed the mother of six. Page 3: Hazard has a history of driving violations, including several in 1 year. At the time of this driving violation, he had been drinking and taking prescription medication.

These are all written up as criminal. Clearly they are people who all have suffered from severe addictions. Maybe the kid, the teenager, you know, just had too many beers and was being a teenager out on the water, but even that raises issues of teen drinking. But 67 percent of the people that we arrest in this country at the time of arrest test positive for one of five drugs.

What are we going to do—you said comprehensive approach—to bring this further to light in this country? I mean, this is the elephant in the middle of the room. We're treating everybody who are committing these crimes as hardened criminals, when probably two-thirds of them after they've committed the crime don't remember what they did, and we've criminalized a public health problem in this country.

No one says that they don't have responsibility for their actions, but can you talk to this issue for us and explain what it is that you think we can do so that these officers don't need to get shot, and these young people don't need to be killed, and these mothers don't need to be killed in drunk-driving accidents because we are treating this as a health problem and not as a criminal justice problem? And maybe we could attack this from the front end rather than through the back end when it's too late and all the people are already killed. Maybe you could tell us maybe through the health system how we could attack this problem.

Mr. KUCINICH. The gentleman's time is expired, but given the gravity of your question, and, Mr. Kerlikowske, being head of this government function, please answer his question as best you can.

Mr. KERLIKOWSKE. Congressman, I know in talking to my colleagues they're as frustrated with the system. Treatment on demand. If someone wants treatment, there should be space, there should be capacity for drug treatment. If they come in for drug treatment in handcuffs, there should be space for them also. If they go to jail for their actions, they should get—and they have an addiction, they should get treatment before they come back out on the street.

Mr. JORDAN. Mr. Chairman, can I?

Mr. KUCINICH. The gentleman's time is expired, but did you want to engage in this?

Mr. JORDAN. Mr. Chairman, you can cut me off if you want, but I think the gentleman from Rhode Island made the point. If I got it right, the first example he cited from today's paper, the guy had two counseling intervention sessions, had a lengthy record. It seems to me if we were focused on the law enforcement side of things, this guy may not have been on the street and may not have been able to do the harm he did to the officer. It sort of proves the point I was trying to make in my questioning. A law enforcement approach with that particular individual might have saved a police officer's life, it looks like to me.

Mr. KUCINICH. I thank the gentleman.

Let's go to Mr. Cummings.

Mr. KENNEDY. If I could?

Mr. KUCINICH. Mr. Kennedy.

Mr. KENNEDY. The substance abuse counseling isn't substance abuse counseling. Substance abuse counseling is doing evidence-based; am I right, Mr. Czar? And that means following what the physicians tell us works. Clearly what they're offering now isn't working because it's not following the evidence of what works and what doesn't. First of all, a number of times this fellow was in and out of——

Mr. KUCINICH. I thank the gentleman from Rhode Island. Mr. Kennedy——

Mr. KENNEDY. Well, the number of times this guy was in and out show that he wasn't even in long enough to benefit from counseling.

Mr. KUCINICH. Thank you, Mr. Kennedy.

Because of the importance of this exchange, this little interplay, I think, is beneficial to the committee, and I appreciate the indulgence of other Members because that section took about twice the amount that we usually would, but this committee has that latitude.

Mr. Cummings, you may proceed.

Mr. CUMMINGS. Thank you very much.

Mr. Kerlikowske, it's good to see you. Welcome to your position. And I just have a few words.

As I'm sitting here listening to what has been stated, and having been the ranking member over the drug subcommittee, I would ask that whatever you do, you try to do what is most effective and effi-

cient. I'm tired of what has been going on with regard to the drug czar's office. Let me explain that to you.

I think the way the drug czar's office is set up in the administration, I think it makes it very difficult, unless they've changed, for you to do your job—not just you, anybody in that position—because basically you're at the mercy of everybody else, as I understand it. Now, you may have changed. And so I think what happens is that there are things that you may want to do, but you got to have the cooperation of the other folk. And what I have found over the years is it seems as if the drug czar's office was not a stepchild, but a distant cousin. And so I'm hoping that this administration—and I am a big supporter of President Obama, I worked very, very hard for him, I'm one of those early supporters. This thing of dealing with drugs is very, very serious. And I think because drugs are considered in our society as a negative issue, a lot of times it's sort of put on—I don't want to say the back burner, because sometimes it's put off the stove.

And so I guess what I'm trying to get to is I hope that you will look at some of the things that you've already talked about. The media campaign, let's determine whether that is truly effective and efficient, because if it's not, scrap it, let's go somewhere else and do something else.

The whole idea of HIDTA, which I think is very important. I know you are familiar with HIDTA. I think HIDTA is very important. And I think in most instances it is effective and efficient because it gives your State, your local and your Feds a chance to work together and to learn from each other and, again, effectively use the limited resources that we he have to address issues.

Another thing we need to look at is the whole issue of effectiveness of treatment. I do believe in my heart that—and we've seen it from testimony coming before this committee—there were a lot of folks that would open up these mom-and-pop shops to give people so-called treatment, when, in fact, they weren't being treated at all. As a matter of fact, they put them in a position where they lost faith in treatment itself because they were not properly treated. So I hope you will take a look at that.

And this whole thing of measuring, you're right. If we can't measure something, there's a major problem. And I don't know exactly what kind of tools you plan to use with regard to measurement, but we've got to be able to see where we're going and see if we are achieving something.

I agree with regard to the war on drugs. We need to get away from that word "war." These are our people. And let me tell you, I come from the city of Baltimore, and I'm inviting you to come to Baltimore to tour with some very interesting sights. I can tell you within five blocks of where I live, I can go and show you an open-air drug market where at around 7 a.m., maybe 6:30, you've got hundreds of people literally selling drugs, a city, sadly, where out of 650,000 people, you got 65,000 addicts. But it's still a great city. But the fact is that it becomes much more difficult to govern, much more difficult to keep it, sustain it, when you've got that drain. And it is a drain, because you're trying to keep people afloat, and the money is like just going through a bucket with a hole in it.

Now, I'm saying that's why I keep talking about effectiveness and efficiency. I know you've got limited resources. But, again, I hope you'll take all that into consideration.

I see my time is about up, but I just wanted to get those comments over to you.

Mr. KERLIKOWSKE. Thank you.

I spent a lot of time in Baltimore when Tom Frazier was the police commissioner and many of my other colleagues, and have visited. My wife did some research in Baltimore. I understand that huge heroin-addicted population and the difficulties. I believe that our staffs are scheduling probably the third visit that I'll make as drug czar, as Director of this office, will be to Baltimore, and I look forward to seeing and hearing more from your perspective.

Mr. CUMMINGS. Well, just make sure I'm there. I want to make sure I'm there.

Mr. KERLIKOWSKE. I understand.

Mr. CUMMINGS. Don't go when I'm somewhere else.

Mr. KERLIKOWSKE. I understand.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. KUCINICH. Let the Chair direct a followup question.

Will you go to Baltimore, and will you be there with Mr. Cummings?

Mr. KERLIKOWSKE. I am planning on going to Baltimore, and I will be with Mr. Cummings.

Mr. KUCINICH. OK. Thank you.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. KUCINICH. The Chair recognizes the gentlelady from California Congresswoman Watson.

Ms. WATSON. Mr. Kerlikowske, did I get it right?

Mr. KERLIKOWSKE. Yes, ma'am.

Ms. WATSON. OK. Thank you.

Does the Obama administration intend to lift the ban on needle exchange programs, and do you plan on funding these programs in your budget for the 2011 fiscal year?

Mr. KERLIKOWSKE. I can tell you that after just 8 days on the job, I have not delved into the needle exchange funding issue. I know it is not in this current budget, but I can tell you that I plan on making it one of my priorities to learn a lot more about this issue. And I will be more than happy to respond back as quickly as I can to you on that.

Ms. WATSON. We would appreciate it.

And the United States with—I think this is 2 million in prison—has the highest rate of incarceration in the world, as you know. And over the past two decades, increasing numbers of Americans have been in prison for nonviolent acts driven by drug dependency. Furthermore, although experts have found little statistical difference among racial groups regarding actual drug use, African Americans account for 37,000—37 percent of those arrested on drug charges, 59 percent of those convicted and 74 percent of those sentenced to prison.

So how do you plan to implement a strategy that treats drug addiction as a public health issue rather than a purely criminal justice concern, and what policies do you plan to implement to alleviate the racial disparities associated with drug treatment?

Mr. KERLIKOWSKE. Right now we are in the process of putting together several things. The President's drug strategy, which will be delivered in 9 months, is one that we're formulating. We're also adding staff to the Office of National Drug Control Policy, including a Deputy Director who's been nominated by the President whose expertise is in treatment and not on the law enforcement side.

Figuring out a way in which we can leverage all of our resources to treat this as a public health, a social policy problem and a criminal justice problem working together would have great benefit not only to the prison population and reducing that inordinate—those costs, but also to improving the safety and security of our neighborhoods and our streets. So I look forward to bringing these staffs on board, working with Congress, listening to the suggestions from Congress as we deliver and put together the President's strategy.

Ms. WATSON. On the day that you were confirmed as Director, the consolidated national drug control budget for fiscal year 2010 was released. And did you have any input into the formation of that 2010 budget, and what significant differences do you think there will be between a 2010 budget and a 2011?

Mr. KERLIKOWSKE. I did not have the opportunity to weigh in at all, and, until confirmed, took absolutely no actions even though I was the nominee. I know that in speaking with the President and in speaking with the Vice President, my position in our office will have a great deal of input in putting together the strategy for the next go-around.

Ms. WATSON. It seems that the disparity between powder cocaine and crack cocaine disadvantages minorities, and we've had trouble in our courts. I mean, we have a large percentage—I'm from California—of our young black males in prison more than are in college, and that statistic cannot continue. So I would hope that as the Director that you would look into that disparity and look into how we can support the programs, walk-in programs.

When I was in the Senate and chairing the health committee, year after year we would introduce bills that would allow storefront treatment centers that people could walk into. The conservative administration always said it would be too costly. Well, it cost the lives and the careers of our young people. So I hope you will look deeply into that as you begin your work.

Mr. KERLIKOWSKE. Please be assured that I will. Thank you.

Ms. WATSON. Thank you.

Mr. KUCINICH. I thank the gentlelady.

The Chair recognizes the gentleman from Massachusetts Mr. Tierney.

Mr. TIERNEY. Thank you very much.

Thank you, Mr. Kerlikowske, for being here today. Can you share with me what the rationale was behind reducing the amount of money that went into the High-Intensity Drug-Trafficking Areas program? Do you have some data or some evidence that contradicts what we've been hearing from law enforcement personnel that, in fact, it's useful and helpful?

Mr. KERLIKOWSKE. I'm a strong supporter of HIDTA. I served on the HIDTA Board in Seattle and believe, as other Members have stated, that they are useful.

I don't have the particular details of the budget issue. I know that the law enforcement agencies would always appreciate more assistance. Meeting with the HIDTA Directors, five of whom I'll be talking with tomorrow in Nashville, is something that I will certainly explore further.

Mr. TIERNEY. I know it's one thing they always want resources, but I'm sure what they don't want is a reduction if they can really put the money to good use. So I would appreciate you examining that with them and then let us know what your result of that; whether you think the $14 million reduction was appropriate, or whether you've revisited it after you've met with them.

Mr. KERLIKOWSKE. I will.

Mr. TIERNEY. Thank you.

Do you have a position on the so-called gateway theory, the idea of focusing resources on marijuana use for young people?

Mr. KERLIKOWSKE. I don't. I've seen—I've read a lot of research and a lot of literature. You cannot deny that people that are using much stronger drugs than marijuana often started with marijuana. I think there is a disagreement among the academics and the researchers on whether or not marijuana is, in fact, a gateway.

Mr. TIERNEY. Do you have a position also on NARCAN?

Mr. KERLIKOWSKE. No, I don't. I've been in office 8 days. I know 36 years of law enforcement. I have a lot to learn.

Mr. TIERNEY. I thought you might have bumped up against it in Seattle.

Mr. KERLIKOWSKE. I've seen the use of the preventives, and I've seen the use of bringing people out of the heroin overdoses by drug treatments, but these are medical areas that actually I'm being briefed on almost immediately.

Mr. TIERNEY. Well, there are some people, obviously, who feel that success actually works counter, because people are going to start relying on it being there, which I think may be a bit of an odd way to look at things on that if you can save a life. But I'll look forward to talking next time we have you in and see what you've developed for a theory on that. Thank you.

I yield back, Mr. Chairman.

Mr. KUCINICH. At the request of a number of members of this subcommittee, we are going to go to another round of questions of Mr. Kerlikowske, and then go to the next panel after that.

Now, in your position, will prevention be a big item?

Mr. KERLIKOWSKE. Yes.

Mr. KUCINICH. Well, given that preventing substance abuse is the most cost-effective method to reduce the cost and consequences of addiction, could you explain why the President's budget proposal to reduce prevention funding by 10.6 percent has occurred? How does that square with your philosophy?

Mr. KERLIKOWSKE. I would tell you that my ability to influence or be involved in this budget process was nil. I know that prevention is an important part of the Obama administration. I will be working very hard on this next presentation and on the President's drug strategy, and that prevention will be an important component.

Mr. KUCINICH. So would you recommend that they not cut funds for prevention?

Mr. KERLIKOWSKE. I actually don't know enough about the details of the 2010 budget, as much as I have looked at tons of material already in just a few days.

Mr. KUCINICH. Are you familiar with the proposed elimination of States' grants portion of the Safe and Drug-Free Schools and Communities Program?

Mr. KERLIKOWSKE. I am.

Mr. KUCINICH. And do you agree that would leave schools that do not receive a grant from the national program without funding for even minimal drug and violence prevention in schools?

Mr. KERLIKOWSKE. Mr. Chairman, I would answer it this way, that any of the programs that are not shown to be effective need to be looked at and either need to be reduced or eliminated, but I do not have the details of how that was evaluated and how that was looked at.

Mr. KUCINICH. Given that, as you said many times, 8 days on the job, I think it would be helpful for this committee to receive from you information on your position as to how prevention programs will manage with a reduction and whether or not most local education associations actually use the money that comes from the Safe and Drug-Free Schools Community Program to leverage other resources and to develop consortia to pool their resources to provide optimally effective programs and services.

We need an analysis from you on that. If you, as you said, have just come into this recently, it would be helpful to understand how your positions will square with some of the budget realities.

Finally, the ONDCP is statutorily required to set quantifiable goals for reducing illicit drug use and the consequences of illicit drug use in the United States, but rarely has done the latter. In particular, the agency has never set quantifiable goals of reducing fatal drug overdoses or the spread of HIV/AIDS, even though rates of both are relatively easy to calculate.

As Director of the ONDCP, you have broad statutory latitude to set both national goals and performance measures. Will you set short and long-term objectives for reducing the harms associated with both drugs and the war on drugs? If so, what performance measures will you focus on? And, finally, will you consider adding additional measurement criteria and performance goals related to drug overdose deaths, HIV transmission rates, and the number of hard-core addicts?

Mr. KERLIKOWSKE. Mr. Chairman, the Metrics and Measures Project is already under way within ONDCP, using a wide variety of data to establish the measures and to see how we are doing against ours goals. It will be very important. It can't be limited to just a few small measures, and I agree with that. We will be asking for a lot of input, and particularly input from the members of the committee and your staff.

Mr. KUCINICH. OK. I yield to Mr. Jordan for 5 minutes.

Mr. JORDAN. Thank you, Mr. Chairman.

Mr. Kerlikowske, the gentlewoman from California I think asked you earlier about the needle exchange program and you said you would get back to her. How soon do you think you can have an answer to this committee about your feelings about that proposal and specifically in light of the President's comments about that concept?

Mr. KERLIKOWSKE. Mr. Jordan, I would tell you that the needle exchange issue, the medical marijuana issue, and several others that have been mentioned here, are all high priorities for me. I am doing my very best to kind of get my arms and head around the agency right now.

Mr. JORDAN. Three months, 4 months, 6 months? What do you think?

Mr. Chairman, maybe it would be appropriate, obviously it is the chairman's call, to have the Director back at some point. He has talked about several times 8 days on the job, which I understand.

Mr. KUCINICH. I was thinking the same thing. Let's have our staffs work together with Mr. Kerlikowske for a followup meeting so we can do some benchmarks and measure the progress. So the answer to that is yes.

Mr. JORDAN. Mr. Chairman, if I could before I forget about it, I would ask unanimous consent to submit two articles from last spring. One says Vancouver's injection site proven ineffective and cost-prohibitive. The other says the U.N. says safe injection sites should be closed.

Just for the committee.

Mr. KUCINICH. Without objection, so ordered.

[The information referred to follows:]

Cong. Jim Jordan
05/19/09 - 2:01 p.m.
AP

Published on *DFAF* (http://www.dfaf.org)

Vancouver's injection site proven ineffective and cost prohibitive

Date: 14 April 2008

St. Petersburg, FL (04/14/08) – Drug Free America Foundation, Inc. today reacted to the final report of Health Canada's Expert Advisory Committee (EAC) indicating that INSITE's drug injection site in Vancouver has proven ineffective and cost prohibitive. Drug Free America Foundation's Executive Director Calvina Fay is urging the Canadian government to withdraw support for the pilot program.

"Based on the findings of the EAC report, it is clear that Vancouver's drug injection site pilot program has been a complete failure in terms of effectiveness and costs," said Professor Fay. According to the report, the Committee found no direct evidence that INSITE positively influenced overdose death rates, rates of addiction or rates of infection. Additionally, the report reveals that only a small percentage of intravenous drug users actually used the facility.

"By concluding the injection site experiment and focusing its energy and resources on treatment and prevention, I am confident that the government of Canada will be moving to a proven course of preventing needless death resulting from illegal drug use and addiction," Fay concluded.

Drug Free America Foundation, Inc., is a drug prevention and policy organization committed to developing and sustaining global strategies, policies and laws that will reduce illegal drug use, drug addiction and drug-related injury and death.

If you would like to set up an interview with Professor Fay regarding the findings of this report please contact John Pastuovic.

Source URL: http://www.dfaf.org/content/vancouver%E2%80%99s-injection-site-proven-ineffective-and-cost-prohibitive

Rec'd via Internet
Cong. Jim Jordan
05/19/09 - 2:00 p.m.
DP

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U.N. Says Safe-Injection Site Should Be Closed

March 11, 2008

News Summary

The United Nations' International Narcotics Control Board (INCB) says that Vancouver's safe-injection facility for drug users violates international drug-control treaties and should be closed, The Province reported March 8.

The U.N. also called for an end to the city's program that distributes clean crack pipes to users. Both programs are intended to prevent the spread of HIV and other infectious diseases among addicts.

Researchers say that Vancouver's Insite program has reduced overdoses and disease transmission, but Canada's Conservative government opposes the program and is expected to use the U.N. report as justification for shutting Insite down. Federal authorization for the program expires in June.

Sen. Larry Campbell, a former Vancouver mayor and Insite supporter, accused the INCB of being "stooges for a failed U.S. war on drugs," while current mayor Sam Sullivan said the U.N. was misinformed about Insite. "The way we've approached drug addiction worldwide has been a failure," Sullivan said. "We need new approaches. We need to be open to innovations."

Mr. JORDAN. Thirty-six years you said, Mr. Kerlikowske, you have been working in the law enforcement field. Tell me just with that experience, what is it that leads a person down this trail? I have my theories. Mine deal, frankly, with family life or lack of family life, particularly a mother and father there to provide some of the guidance and discipline that parents provide.

But in your 36 years, just give me what is it that pushes a young person into this terrible, terrible lifestyle?

Mr. KERLIKOWSKE. You know, when I was pretty young in this business, I think I had all the answers, and now that I am almost 60, I am not sure I have even the right questions.

I would tell you that I think it is infinitely complex. I think it begins with parents. I think issues of prenatal care, parent coaching, early childhood programs, Head Start, neighborhoods, communities, religious, faith-based, etc., are all important. I also think that the medical testimony about addiction as a disease is also of critical importance.

If I knew the one answer that heads them down that path——

Mr. JORDAN. What is your best guess? You talked about what you thought you knew when you were young. It reminded me of the statement, Mark Twain had a great line. When I was 10, my dad knew everything. When I was 20, he didn't know much of anything. Now that I am 30, I am surprised how much he has learned in 10 years. It sort of works that way for all of us, I think.

But if you had to say one thing, would you say it is the lack of a mom and dad there doing the things that parents do?

Mr. KERLIKOWSKE. I would say family and parent issues, neighborhood and community are of critical importance. Getting parents off to the right start and getting children off to the right start would make all of my former colleagues', police chiefs and sheriffs, jobs a heck of a lot easier.

Mr. JORDAN. Let me ask you one other thing real quick here. The Southwest Border Counternarcotics Strategy you mentioned in your testimony, your prepared testimony, that this has undergone an accelerated review and update. Talk to me about that.

Again, this sort of gets back to my first round questioning, when we talked about what is going on on the border. Talk to me about that in the remaining minute I have.

Mr. KERLIKOWSKE. I have had an opportunity to look at what would be the final draft of that policy. I have not had the opportunity to talk with the Vice President and the Secretary of the Department of Homeland Security about it. But I know that earlier she had asked that ONDCP be much more heavily involved in this issue, and I plan on taking that up as quickly as I can.

Mr. JORDAN. Thank you, Mr. Chairman.

Mr. KUCINICH. The Chair recognizes Mr. Kennedy.

Mr. KENNEDY. Thank you, Mr. Chairman. I would like to for the record just submit the articles that I was referring to before.

Mr. KUCINICH. Without objection, so ordered.

[The information referred to follows:]

The Providence Journal projo.com

Rhode Island news

Routine call for officer becomes life-and-death situation

03:30 PM EDT on Tuesday, May 19, 2009

By Tom Mooney

Journal Staff Reporter

David J. Catalano, 29, of 10 Wasp Rd., North Kingstown, left, appears in District Court, South Kingstown, Monday, where he is ordered held without bail on five felony charges. He is accused of driving into and killing a gas station employee in East Greenwich on Sunday and later shooting North Kingstown police Officer Travis Maiato, inset, who had come to Catalano's house to inquire about the incident.

EAST GREENWICH — Clifford LeValley spent a career at Electric Boat and enjoyed a second vocation being everyone's handyman. If one of his three children needed their lawn cut or a gutter cleaned, LeValley often beat them to the mower or the ladder.

Maiato

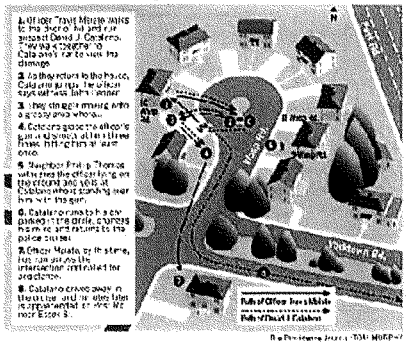
The same held true at Willie's Shell station where LeValley, 66, had worked part time for decades, cultivating friendships with the regular customers. So there was nothing unusual when a motorist pulled into the station a few minutes before 1 p.m. Sunday asking to use the air pump and LeValley insisted on checking her tire pressure himself.

He was there by the pump at the front of the station, doing what he always did, when a black Ford Explorer inexplicably veered off Post Road and into the garage lot. The SUV pinned LeValley against the car or the front of the station. Then it backed up and sped south down Post Road.

Before the next half-hour passed, the police say, the driver of the SUV, David J. Catalano, 29, wrestled a .40-caliber pistol away from a North Kingstown police officer, shot him once in the shoulder and fired two other shots by the officer's head before escaping in the officer's cruiser. Pursuing officers from North Kingstown, East Greenwich and the state police forced him off the road about a mile away and pulled him out through a passenger window.

On Monday, in District Court, South Kingstown, Judge Walter Gorman ordered Catalano held without bail on numerous charges, including attempted murder and leaving the scene of an accident, death resulting.

Officer shot in North Kingstown



Journal graphic / Tom Murphy

Meanwhile, in the service bays of the Shell station at 5819 Post Rd., those who knew LeValley cried for a lost friend.

Two miles away on Wasp Road in North Kingstown, neighbors of Catalano's retold what they had seen Sunday afternoon involving the man who, records show, has been arrested and imprisoned several times since 2004 on a host of charges, including instances of assaulting one police officer and eluding another.

Within minutes of the hit-and-run, say the police in North Kingstown and East Greenwich, a motorist called the police saying he had seen the incident and was following the Ford Explorer south on Post Road toward North Kingstown. The motorist gave the police a license plate number.

Police tracked the vehicle's registration to Catalano's address, 10 Wasp Rd. The East Greenwich police requested assistance from neighboring North Kingstown.

Officer Travis Maiato, 31, on the force for 7 ½ years, took a dispatcher's call to go to the address where Catalano lives with his mother, Elizabeth. She had also been in the Explorer when it swerved into the Shell station, never leaving a skid mark.

Maiato's orders were routine for such an ordinary "notification" visit, the police say: tell Catalano he should contact East Greenwich police; he was wanted for questioning in a hit-and-run accident.

Maiato, who has won departmental commendations and helps train police recruits, drove into the short cul-de-sac that sits just off Yorktown Road and is encircled by seven duplexes. It was about 1 p.m. He parked between the first and second duplexes on the left, numbers 6 and 10 Wasp Rd.

Across the cul-de-sac, John Dennen, 19, watched Maiato's arrival from a living room window. Dennen and his mother had just moved into their apartment on Saturday.

Dennen said Maiato examined the black SUV, parked beside the grassy island in the middle of the cul-de-sac. Then he walked up to the door of 10 Wasp Rd. Dennen said Maiato and a man later identified as Catalano walked out together and were talking beside the SUV, when he left the window to go upstairs.

The next thing he heard were gunshots.

Police theorize a fight broke out after Catalano heard over Maiato's radio a transmission that the accident had involved personal injuries and that North Kingstown police should hold Catalano until East Greenwich police arrive.

Phillip Thomas, 24, was in the apartment adjacent to Dennen's when he heard the first gunshot.

He said he stuck his head out of an upstairs bedroom window, looked across the street, and saw a man in a white shirt and jeans, holding a gun and standing over a crouched police officer. The two were on a thick green lawn at 6 Wasp Rd. The man fired two more times at the officer, Thomas said.

"I started screaming and the guy looked at me," said Thomas.

Thomas said he ran downstairs, looked again out the window, and saw the man running around the black SUV as if trying to decide whether to jump in it or not.

"All the neighbors were coming out, and I was screaming 'He's got a gun! He's got a gun!' I shouted to

him, 'Put the gun down, you're just going to make it worse for yourself.' "

That's when the man pointed the gun at him, Thomas said.

Thomas said the police officer ran out of the cul-de-sac and across Yorktown Road as Catalano jumped into the officer's cruiser.

Kathi Robbins of 20 Yorktown Rd. was coming out of her apartment when she said she saw a police officer, his shirt and pants torn, run across her front lawn and duck behind a neighbor's parked car. The officer screamed into his radio on his shoulder, " 29!, 29!" as he knelt behind the car.

A moment later, Robbins said, a cruiser pulled out of Wasp Road driven "by what looked like a young kid in a white shirt. I thought that was kind of weird, but then I thought maybe he's a detective."

The cruiser drove past the car that Maiato was using as cover and turned north onto Post Road.

Robbins ran over to the officer. "His hands were all scraped up," she said. "I asked him if he was all right, and he said he'd been shot. You could tell his adrenaline was going, but then he started looking really tired."

Responding East Greenwich officers saw North Kingstown police pursuing one of their own cruisers as they sped south on Post Road. They were able to box Catalano in at Post and Essex roads in North Kingstown and force him off the road. Those officers broke a side window and pulled Catalano out.

One .40-caliber slug grazed Maiato's shoulder and another struck his bulletproof vest in the back, said North Kingstown Police Chief Edward A. Charboneau. The vest "definitely" helped save his life, the chief said. Maiato, who was released from Rhode Island Hospital on Monday, "is very lucky he is alive," said Charboneau. "He told us he heard one [bullet] whistling by his ear."

Catalano has a long history of trouble, going back at least to his late teens. He's been arrested at least a dozen times and been convicted on crimes ranging from assault to drug possession to resisting arrest. When he's served time at the Adult Correctional Institutions, it's been several months at a time for violating suspended sentences on previous convictions.

Judges have ordered him to attend substance-abuse counseling several times over the years, and lately, mental-health treatment.

Two months ago, the East Greenwich police sent him to Kent Hospital to be evaluated after he walked into the police station, smelling of alcohol and behaving erratically. He ranted about a woman, demanding that she get out of his life. But when the officers asked how they could help him, Catalano yelled that he would fight them. "Who do you think you are? I'll bang you out. Arrest me now. I don't care...." he yelled, according to a police report. He was handcuffed and taken to Kent Hospital.

Five years ago, he swore at Johnston police officers and poked one of them in the face after he had left a bar. In 2006, he served 30 days at the ACI for eluding a police officer.

Related to Sunday's shooting, the police have charged Catalano with assault with intent to murder, discharging a firearm during the commission of a crime of violence, assault with a dangerous weapon, stealing a police cruiser and stealing the officer's gun. He is also being held as a violator of his probation for a disorderly conduct conviction in March. He faces life in prison if found guilty of the charges.

LeValley was alert and talking when rescue workers came to his aid Sunday afternoon at the Shell station.

He died three hours later at Rhode Island Hospital.

With staff reports by: Amanda Milkovits, C. Eugene Emery Jr., Kate Bramson and Thomas J. Morgan.

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Rhode Island news

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Teen pleads no contest in boating death

01:00 AM EDT on Tuesday, May 19, 2009

By Katie Mulvaney

Journal Staff Writer

GREENBERG

PROVIDENCE — The teenager accused of striking and killing his friend with a boat on the Barrington River in 2007 took responsibility for his role in the death Monday in Superior Court.

Ryan A. Greenberg pleaded no contest to reckless boating, death resulting, in the death of 17-year-old Patrick Murphy after a day of boating with other teens on the river July 17, 2007.

The charge carries a maximum sentence of 10 years in prison. Under the terms of the plea deal, Greenberg will face 2½ to 5 years in prison with the rest to be suspended with probation at his sentencing July 22.

In exchange, the state attorney general's office dismissed a second-degree murder charge as well as two misdemeanor counts: refusal to submit to a chemical test and possession of alcohol as a minor.

Greenberg, appearing grim with dark bags under his eyes, said little, answering simply "Yes, Your Honor" when asked by Judge Daniel A. Procaccini if he understood the agreement. He remains on home confinement at his parents' home on Glen Drive in Providence.

Murphy's parents, John and Phoebe, and two of Murphy's siblings looked disconsolate as they observed the proceedings from the jury box, watching Greenberg intently.

The Murphys' lawyer, Todd White, said afterward the family "is relieved that Ryan Greenberg is taking responsibility."

Deputy Attorney General Gerald J. Coyne and Special Assistant Attorney General Christian F. Capizzo, prosecutors from Attorney General Patrick C. Lynch's office, had kept them apprised of the plea

negotiations, White said. "They are satisfied with that as a parameter," White said of the 2½-to-5-year sentencing timeframe.

The Murphys plan to speak at the sentencing, White said. Greenberg, who turns 19 Tuesday, will also have the opportunity to address the court at that time.

Lynch, who attended the court session, said afterward that the proposed sentence was appropriate following plea discussions between prosecutors and defense lawyers. The state probably could have proven second-degree murder, he said, but the agreement will spare the Murphy family the discomfort of a long trial.

Lynch held Greenberg accountable: "A young man perished because of an intentional act. It was not an accident."

The state would have had to prove Greenberg killed Murphy with malice, as opposed to just reckless disregard, to obtain a second-degree murder conviction, said Michael J. Healey, Lynch's spokesman. "Proving that degree of intent past reckless boating and proving it beyond a reasonable doubt would have been challenging," he said.

Authorities say Greenberg was at the wheel of a motorboat when it struck and killed Murphy, who had been kneeboarding behind the 20½-foot Sailfish in a popular waterskiing area south of the Massasoit Avenue Bridge.

A reconstruction report by state environmental police said the pair, classmates at Barrington High School, sparred moments earlier about Greenberg's boating and Murphy's kneeboarding skills. Greenberg "throttled up" and pointed the boat at Murphy, striking him, it said. The medical examiner ruled that Murphy died of blunt- and sharp-force injuries.

Investigators found evidence Greenberg drank alcohol that day, according to the report, and a preliminary medical examiner's report indicated Murphy had alcohol in his system.

Greenberg was charged with second-degree murder; reckless boating, death resulting; underage possession of alcohol and refusal to submit to a chemical test. In January 2008, he pleaded not guilty to all counts.

Greenberg was 17 at the time, but a Family Court judge waived jurisdiction, clearing the way for his being tried as an adult in Superior Court.

William P. Devereaux, Greenberg's lawyer, said Monday he had evidence showing Greenberg did not gun the boat at Murphy at 27 mph over 70 feet, as others had said. "He certainly wasn't driving the boat to kill or injure Patrick Murphy ..." he said. "This certainly was a tragic set of circumstances."

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Rhode Island news

Shooting suspect possessed lengthy criminal record

08:23 AM EDT on Tuesday, May 19, 2009

By Amanda Milkovits

Journal Staff Writer

David J. Catalano is being held on five felony charges.

The Providence Journal Frieda Squires

David J. Catalano's criminal record goes back more than a decade, with arrests in several communities on charges ranging from disorderly conduct to assault and drug possession. He has been ordered to attend substance-abuse counseling at least every other year.

Catalano is being held without bail on five charges stemming from the Sunday shooting of North Kingstown police Officer Travis Maiato, and as an alleged violator of a suspended sentence from March. He is expected to be brought District Court on Tuesday on three charges stemming from the death of Clifford LeValley.

Catalano has pleaded no contest to the following 16 charges in 11 different cases during that period. He has been to prison several times.

•1998, Johnston: driving while impaired — fined and lost his license for one month.

•2000, Rhode Island State Police: attempted breaking and entering, conspiracy — five-year sentence deferred, until he violated sentence in 2005.

•2002, Cranston: disorderly conduct — six-month suspended sentence and probation, ordered to undergo substance-abuse counseling.

•2003, Cranston: receiving stolen goods — one-year suspended sentence and probation. He violated the suspended sentence in 2004 and was sentenced to four months.

•2004, Johnston: simple assault, disorderly conduct and resisting arrest — one-year suspended sentence and probation, plus substance-abuse counseling.

•2004, Providence: simple assault and reckless driving — one-year suspended sentence and probation, no loss of license, all costs waived, substance-abuse counseling. He violated this sentence in 2005 and served 30 days.

•2005, West Warwick: simple assault — one-year suspended sentence and probation.

•2006, Cranston: eluding police — one-year suspended sentence and probation, no loss of license, ordered to attend substance-abuse counseling. He violated this sentence in 2006, and was sentenced to 30 days.

•2006, Providence: felony possession of a controlled drug and resisting arrest — two-year suspended sentence and probation, ordered to attend substance-abuse counseling. He violated this sentence in 2007, sentenced to 60 days.

•2007, North Kingstown: domestic vandalism, domestic assault, and resisting arrest — one-year suspended sentence and probation, ordered to attend counseling for mental health, domestic abuse and substance abuse.

•2009, East Greenwich: disorderly conduct — six-month suspended sentence and probation.

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Mr. KENNEDY. Thank you. I would like to also submit a letter from my own State Department of Health. We have a needle exchange program in Rhode Island that has reduced transmission of HIV.

Mr. KUCINICH. Without objection, so ordered.

Mr. KENNEDY. Thank you. If I could go to the issue of getting your support for this SBIRT, early screening, brief intervention and treatment, if we could integrate into our health care system drug counseling, screening and so forth, and make it as routine as diabetes screening or anything else, it would destigmatize it and it also help us on the prevention that the chairman said is the cheapest way for us to tackle these problems.

If you had it with every doctor, no matter what specialty they had, and you reimbursed them for it, and I mean white coat docs, so they don't have to be mental health docs or substance abuse specialty docs, every doc got to be trained in this, can you talk about how that would be really revolutionary in terms of advancing this cause in terms of public health? And would you be able to join us in the effort to write to the medical boards that put together these tests for medical schools and encourage them to put more questions on the tests vis-a-vis drug and alcohol training and questions and mental health so as to encourage medical schools to put their curricula more in line with the patients that their future physicians are going to see? That is, every patient they are going to see is going to have to have a cross-section of being a whole person, not only there for whatever specific malady they might be going to a specialist for, but they are also going to have a complement of mental health and emotional issues as well, and now their doctors are going to be also able to be trained to deal with that, just maybe in a cursory public health way.

Mr. KERLIKOWSKE. I have had two initial briefings on the program. I am a supporter of the program. The analogy would be as we educated and informed physicians to ask patients, particularly their female patients, about domestic violence and inform them and educate them about domestic violence, that it can help to reduce that. Having the physicians also do the screening and the discussion with their patients, regardless of what they come in to see that physician for, about addiction and substance abuse, would be a great step forward, and I am supportive of that.

Mr. KENNEDY. As my colleague Mr. Cummings mentioned, there are all kinds of folks out there hanging their shingle saying they are drug treatment folks, and as my other colleague Mr. Jordan said, you know, some of these treatment things just don't work. Here is evidence that this guy was in umpteen different treatment things and he never got well.

Are you for making sure we have some national standards on putting in place maybe JCAHO or NCQA standards for treatment facilities, just like we have for every other health facility, so that we can implement what works in the treatment world?

Mr. KERLIKOWSKE. Congressman, I am not prepared to talk about whether or not I would support particular standards. I would tell you that the treatment issues are very important to me, people looking at treatment as not just a 12-step program or a 30-day inpatient program as being a measure of success. There are a lot of

people that take medications for high blood pressure for their entire lives, they take statins for cholesterol, and looking at treatment perhaps in a different way than just in and out and cured is probably not the best viewpoint.

Mr. KENNEDY. Well, I would just say that airline pilots and doctors have 96 percent success rates in drug treatment. Well, they have to. Obviously, they are flying our planes and operating on us. Let's get what works and appropriate it to everybody.

Thank you.

Mr. KUCINICH. The gentleman's time has expired. Thank you very much.

The Chair recognizes Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Let me ask you this: You know, we authorized ONDCP back in 2006 when I was the ranking member. Tell me, we are going to hopefully do it in 2010, what are your recommendations for topics we should be addressing? Are you familiar enough to answer that?

Mr. KERLIKOWSKE. I would tell you that in looking at the reauthorization I was surprised at the level of detail and complexity, and I think it reflected disappointment with Congress' view of how ONDCP was operating. I would hope that in the intervening time that we would develop a relationship and trust about what works and how we can come together and that during the reauthorization process that we be given the tools at ONDCP to be more effective than we have been in the past.

Mr. CUMMINGS. Just recently, about a month ago, as a matter of fact, a group of us traveled to Panama, Colombia, Brazil, and Mexico. And it is so interesting in Mexico the top law enforcement officials were telling us, and you have heard the stats, I think he said 80 or 90 percent of the guns, and being in law enforcement, a law enforcement person, I am sure you can sympathize and empathize, were coming out of the United States, and these were the same guns that were being used to fight the police and the military with regard to drugs.

And I am just trying to figure out how—the President is in a very tough position. You have a country who basically says, we want our guns. You have the NRA with their position. But at the same time you got Mexico which is saying, United States, you are largely responsible for our problems. One, you are consuming the drugs; and, two, your guns are coming down to us. So we have a double whammy here.

I mean, how do you make your voice heard under those circumstances, considering all the political ramifications? This is very real.

What they said to us is they believe, I am talking about the high-ups. I am not talking about folks—I am talking about the top people. They told us that this Mexican situation, drug problem, is already spilling over into the United States and it is going to get worse.

Then we went to Colombia. President Uribe, who we met with, literally begged us to make sure when we came back to the United States that we did everything in our power to make sure that there was maximum cooperation between the United States and Colombia with regard to drugs. That was very personal to me, because

90 percent of the drugs that come to Baltimore come out of Colombia. So I am trying to figure out how you are going to make your voice heard.

You were selected for a reason. I don't know all the background, but I am sure there were some interviews and you had to say this is my plan, this is what I hope to do. And everything I have heard about you is you are a no-nonsense person, you are very serious about what you do. But I am trying to figure out how do you see your way in addressing issues like that? Because this is a serious business. And as the President of Colombia said, you know, it would be good to be able to stop it here because no matter—I mean, when it gets at your shores, it has done and will continue to do a lot of damage.

Mr. KERLIKOWSKE. You know, at this point in my career I didn't want to come to Washington without being able to make a difference, Congressman. I can tell you that all of my association with all of my colleagues across the country, they want to be a part of this.

I was very heartened by the immediate steps Secretary Napolitano took to reduce guns flowing into Mexico and also bulk cash-flowing into Mexico. I have had several briefings just within the last week on Mexico, and I know that with our Southwest Border Strategy about to be delivered, that those issues have been added and will be addressed.

I have never been a shrinking violet on a lot of these tough issues, and I don't plan on changing my stature in this administration.

Mr. CUMMINGS. Thank you.

Mr. KUCINICH. I thank the gentleman.

The Chair recognizes the gentlelady from California.

Ms. WATSON. I remember going down to Cuba and we met with Fidel Castro about 4 or 5 years ago, and he said that you know, if you could relax the restrictions, he says we are 90 miles of your coast, and we see the boats coming through here and going up to the upper 48, and he said if we could do interdiction together we could stop that traffic.

I am just wondering, do you see a time, and I would hope under your leadership because we need it, a drug czar, that we join with the Cubans in interdicting this drug trade?

Of course, we have a big problem, because that is where the money is. We are having problems in California over our border. Tijuana, right over the border to Los Angeles. Of course, they are having more in Texas and New Mexico.

But do you see a future where we can join with Cuba in interdicting and we can—I guess we have to go back to the President, because I see the problem really at the top. Our President Barack Obama was there a few weeks back and met with the President. But we have to join, both countries and some of the island nations, if we are going to stop the flow.

But the need is so great for drugs here, and I think a lot of the advertising that we see on television and we hear on radio contributes to that. "Take something to feel better." Well, when that something wears off, you still feel the way you did, or even worse than before.

What do you see for the future? What would you lay out as a plan to join with other countries and have a united effort to stop the flow?

Mr. KERLIKOWSKE. Having spent some of my career in Florida, I was certainly familiar with the steps that were taken. One of the next trips I will be taking will be to Key West to meet with the joint task force that works that entire Caribbean-South America-Central America, the entire region. So I am looking forward to learning a lot about that.

I can tell you that it is probably premature for me to actually even engage in a thought right now about the relationship with Cuba when it comes to drug interdiction, but I can tell you that shortly after I visit with the commanders in Key West and spend more time with the State Department officials, I will know an awful lot more about that issue.

Ms. WATSON. Thank you. I yield back.

Mr. CUMMINGS [presiding]. Thank you very much. Again, we want to thank you for your service. We look forward to working with you. The challenges are indeed great and you have a major, major job. I have often said our children are the living messages we send to a future we will never see. The question becomes, will we send them to a future?

So we know that you are up to the task. We look forward to working with you closely because we again want you to be most effective and efficient. Thank you again.

Mr. KERLIKOWSKE. Thank you all very much.

Mr. CUMMINGS. We will call now the second panel. Gail Christopher, the Chair of the National Academy of Public Administration Panel on the Office of National Drug Control Policy; John Carnevale, internationally recognized expert in the field of drug policy, President of Carnevale Associates, LLC; Professor Peter Reuter, Professor in the School of Public Policy and the Department of Criminology at the University of Maryland; and Bobby Charles, the Charles Group, LLC, the President of that organization, after serving from 2003 to 2005 as Assistant Secretary of State for International Narcotics and Law Enforcement.

I am sorry, you all have to stand up again. I have to swear you in. This is one of the few committees where you have to do this.

[Witnesses sworn.]

Mr. CUMMINGS. Ms. Christopher. It is Ms. Christopher? Doctor, I am sorry. I always try to make sure I give people their due. Those degrees are hard to come by. For me it was, let's say it like that.

STATEMENTS OF GAIL C. CHRISTOPHER, PH.D., CHAIR, PANEL ON THE OFFICE OF NATIONAL DRUG CONTROL POLICY: BUILDING THE CAPACITY TO ADDRESS THE NATION'S DRUG PROBLEMS, NATIONAL ACADEMY OF PUBLIC ADMINISTRATION; JOHN CARNEVALE, PH.D., PRESIDENT OF CARNEVALE ASSOCIATES, LLC; PETER REUTER, PROFESSOR, SCHOOL OF PUBLIC POLICY AND DEPARTMENT OF CRIMINOLOGY, UNIVERSITY OF MARYLAND; AND ROBERT B. CHARLES, PRESIDENT, THE CHARLES GROUP, LLC

STATEMENT OF GAIL C. CHRISTOPHER, PH.D.

Ms. CHRISTOPHER. Thank you, Chairman Cummings, Ranking Member Jordan, and distinguished members of the subcommittee. Thank you for inviting me here today. I am honored to appear before you to discuss the National Academy of Public Administration's 2008 study and report entitled "Building the Capacity to Address the Nation's Drug Problems."

It was my pleasure to chair the Academy's ONDCP panel of six members with diverse backgrounds in fields such as public health, social policy, law enforcement, public management, budget and policy analysis.

The purpose of the congressionally mandated study was to provide insights into changes and improvements that could make ONDCP more effective in the future. Underlying all of its recommendations is the panel's firm belief that ONDCP's adoption of a comprehensive approach to multiyear strategic planning informed by the best available data will help the organization to accomplish its mission. The panel's recommendations embody principles, tools, and processes that will maximize ONDCP's effectiveness under any administration and any director.

The ONDCP challenge is to compile a comprehensive strategy that overlays the strategic plans of the numerous diverse agencies and ties the many pieces together in a common, national program, without conflicting with the individual agency's strategic plans and budgets.

Let me begin by acknowledging the very encouraging way in which the new ONDCP Director Kerlikowske, with the support of Acting Director Ed Jurith, has adopted a very energetic agenda to resolve many of the issues that the panel reported and that my written testimony describes.

His endorsement of a comprehensive, multiyear National Drug Control Strategy, the creation of a policy budget steering group, reestablishment of the Drug Demand Reduction Interagency Working Group, commitment to reaching out to stakeholders, and the variety of efforts he has undertaken to reinvigorate the ONDCP work force should have a dramatic and positive impact on ONDCP's mission and its success.

I will summarize the following selected recommendations which relate to the issues this subcommittee has identified for this hearing and would ask that the complete report be entered into the record.

ONDCP should develop a comprehensive, multiyear National Drug Control Strategy that is informed by high quality and diverse data that covers all age groups, illicit drugs and regions of the Na-

tion. ONDCP should bring to bear the full range of the Nation's drug control expertise and build an internal culture that values critical inquiry, open debate and pragmatic decisionmaking.

ONDCP should develop a comprehensive national drug budget summary informed by that multiyear strategy which incorporates total estimated Federal expenditures for all supply reduction, demand reduction and other Federal drug control activities, as well as State, local, and tribal affairs activities related to drug control.

Further, Congress should modify ONDCP's oversight responsibilities relative to individual agency drug budgets so as to tie its review more closely to the annual OMB budget review process.

ONDCP should no longer require drug control agencies to provide performance reports that merely duplicate the GPRA and PART data that is gathered for OMB. The panel believes that ONDCP's energies are better spent assisting agencies in improving the performance measures that they use to generate the data so that the measures align with the overall drug control strategy. In addition, ONDCP should continue working on measures that assess the aggregate performance of drug control agencies in addressing the goals of the national strategy.

ONDCP should work to create a more collaborative and consultative environment in order to increase its effectiveness in its relationships with Congress, the National Drug Control Program agencies and stakeholders throughout the Nation, and we believe that process has already begun with the new administration.

ONDCP should comply with statutory requirements, provide information to Congress in a more timely manner, increase the ability of the drug control agencies to have meaningful input into the substance of the strategy, use working coordinating committees to expand its outreach capabilities, and institute a regular feedback mechanism with National Drug Control Program agencies and stakeholders.

As ONDCP celebrates its 20th year of existence, the panel believes the organization has the opportunity to enhance its effectiveness and its credibility, increase transparency, streamline its organization, simplify its work processes, bolster its work force management, and improve and leverage critical relationships. Seizing this opportunity can translate into increased organizational capacity to address the Nation's drug challenges with positive implication for the Nation's public health and certainly for the Nation's future.

Thank you, and I would be happy to answer any related questions.

[The prepared statement of Ms. Christopher follows:]

Gail Christopher
Panel Chair
National Academy of Public Administration
Before The Domestic Policy Subcommittee
of The Committee on Oversight and Government Reform
May 19, 2009

Chairman Kucinich, Ranking Member Jordan, and distinguished Members of the Subcommittee, thank you for inviting me here today. I am honored to appear before you to discuss the 2008 National Academy of Public Administration's Panel study and report on the Office of National Drug Control Policy (ONDCP) entitled "Building the Capacity to Address the Nation's Drug Problems."

By way of introduction, I am Vice President of Health for the W. K. Kellogg Foundation; Executive Director, Institute for Government Innovation, JFK School of Government, Harvard University; Co-Chair of the National Academy of Public Administration's (the Academy) Advisory Board on the Alliance for Redesigning Government; and it was my pleasure to chair the Academy's Panel on ONDCP. The Panel that conducted this study and its report comprised six members with diverse backgrounds in fields such as public health, social policy, law enforcement, public management, budget, and policy analysis.

Genesis of ONDCP Study

In the FY 2008 Consolidated Appropriations Act, Congress directed the Academy to conduct an independent study and analysis of ONDCP's organization and management. From the Congressional perspective, the purpose of the study was to provide "insights into changes and improvements that could make ONDCP more effective in the future."

In response, ONDCP contracted with the Academy to conduct an independent study of its: 1) Structure, Organization, and Management, 2) Resource Management, Planning, and Budgeting, 3) Hiring, Recruitment, and Utilization of Personnel; and 4) Policy Development, Coordination, and Implementation.

Within the broad areas of the contract, ONDCP requested that the Academy Panel assess the following topics during its review: (1) human capital management, including workforce utilization and diversity; (2) the data it should collect in support of the National Drug Control Strategy and its internal data management system requirements; (3) stakeholder relationships with drug control agencies, Congress, and others; and (4) strategies for communicating with stakeholders and the public.

The Panel conducted extensive research and analysis; an in-depth review of ONDCP's governance structure, statutory requirements, budget, policies, and procedures; more than 135 interviews with ONDCP staff, National Drug Control Program agency representatives, and stakeholders; effective practice comparisons; and workforce analysis.

Findings and Recommendations

Underlying all of its recommendations was the Panel's belief that ONDCP's adoption of a comprehensive approach to multi-year strategic planning, informed by the best available data, will help the organization to accomplish its mission. Without such a well-coordinated, well-substantiated vision in place, it is impossible to build supportive relationships around common, articulated goals. In the aggregate, the Panel's recommendations embody principles, tools, and processes that will maximize ONDCP's effectiveness under any Administration and any Director, regardless of party or philosophy.

In its deliberations, the Panel developed five key recommendations: 1) Develop A Comprehensive, Multi-Year National Drug Control Strategy Informed by a Variety of Data, 2) Build a Collaborative and Consultative Culture, 3) Develop a Comprehensive National Drug Control Budget Summary and Modify Oversight Processes, 4) Streamline the Organization and Rebalance the Workforce, and 5) Implement Effective Human Capital Policies and Practices.

Today, I would like to focus on the issues identified by the Subcommittee: the strengths and weaknesses of ONDCP's policy development, coordination, and implementation, as well as how ONDCP can: 1) develop a comprehensive National Drug Control Strategy, Budget, and Performance Measurement System; 2) build a collaborative culture and more effective management structure; and 3) enhance its overall credibility, accountability and effectiveness.

National Drug Control Strategy

Congress created ONDCP in the Anti-Drug Abuse Act of 1988 to oversee and coordinate implementation of a National Drug Control Strategy (Strategy) as well as to develop policies, priorities, and objectives for the nation's drug control program. Prior to ONDCP's establishment, the Government Accountability Office (GAO) issued numerous reports consistently finding that the nation's complex drug control responsibilities were fragmented among multiple federal agencies.

The first National Drug Control Strategy was developed by ONDCP when the concept of strategic planning was relatively unknown in government. It was not until 1993 that the Government Performance and Results Act (GPRA) mandated that all federal agencies engage in strategic planning and performance measurement, beginning September 30, 1997. [1] Today, all agencies and departments have their own strategic plans and are required to provide performance plans to the Office of Management and Budget (OMB) with accompanying performance indicators.

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[1]The Government Performance and Results Act of 1993 (GPRA) requires agencies to submit a strategic plan with a comprehensive mission statement, goals, and objectives; a description of how the goals will be achieved; a description of performance goals included in the plan; an identification of external risk factors; and a description of how programs will be evaluated. The strategic plans are to cover a period of not less than five years and to be updated every three years.

Strategic plans are intended to identify where an organization is going and how it is going to get there. In an article on Strategic Planning in Government, Dr. Berwyn E. Jones describes Strategic Planning as the identification of a desired long-range outcome and the development of a sequence of actions to achieve it, based on analysis of the organization's resources and its environment.[2]

Strategic planning has traditionally been a "top-down" process with only management having a "need-to-know." According to Dr. Jones, modern organizations, particularly those staffed with "knowledge workers," tend to involve a cross-section of the staff in preparing the strategic plan, in order to bring together wisdom from all levels and areas of the organization. By involving many people, management also obtains broader support for the plan and wider understanding of agency purposes and goals

The challenge for ONDCP is to compile a comprehensive National Drug Control Strategy that complements the strategic plans of the numerous drug control agencies without contradicting them and integrating the many pieces of the drug control effort in a common National Drug Control Program. This is particularly difficult considering the wide diversity among the many control drug programs. In the words of one drug expert interviewed by the Academy, "there is no way that Coast Guard ships doing interdiction on the open seas are in any way tied in with treatment programs in a local clinic."

During the Panel's review, numerous officials in ONDCP's drug control partner agencies were interviewed and a partner agency survey was conducted. These officials described the National Drug Control Strategy as having little applicability to their day-to-day operations, and few of them actually had a copy of the Strategy. Instead, they said they derived their direction from their agency or department strategic plans and described the National Drug Control Strategy as the President's Strategy, not their own.

Further, a number of drug control partner agency officials and other drug control stakeholders criticized recent ONDCP Strategies for narrowly focusing on youth and marijuana to the detriment of other age groups and other illicit drugs, such as Methamphetamine. In addition, recent Strategies were criticized for omitting a full discussion of the consequences of drug abuse.

The Panel believed it was important to conduct a detailed assessment of the content of the National Drug Control Strategies and selected a 10-year period from 1999 to 2008 to assess its focus and changes over time. Research revealed that the contents of the Strategy differed widely over the 10-year period. References to the youth category represented over 80 percent of the population references each year, and over 90 percent in some recent years, thus demonstrating the heavy emphasis ONDCP placed on young people in its National Drug Control Strategy during the past ten years.

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[2] *Strategic Planning in Government—The Key to Reinventing Ourselves*, Berwyn E. Jones, http://www.dau.mil/pubs/pm/pmpdf96/jones.pdf

In regard to the types of drugs discussed in these Strategies, the Panel found that marijuana was the most frequently mentioned drug in five of the ten years (2001, 2003, 2004, 2007, and 2008). Cocaine was the most frequently mentioned drug in three years (2002, 2005, and 2006). Alcohol was mentioned most frequently in 1999 and 2000. Methamphetamine had the lowest relative frequency of reference in 2003, but rose steadily in 2004, 2005, and 2006 during a time when there was mounting Congressional pressure on ONDCP to recognize the problem posed by this synthetic drug.

It is important to note that there are numerous hidden consequences of drug use and abuse that may increase federal and state expenditures. Examples include emergency room visits and medical treatment costs, foster care and child welfare services, juvenile and criminal justice system costs as well as employer losses.

Because ONDCP is statutorily mandated to consider the consequences of drug use, the Panel examined the frequency of references to those consequences in the Strategies from 1999 to 2008. General references to the consequences of drug use decreased from 2001 to 2005 and increased slightly in 2006 and 2007. Tuberculosis, HIV/AIDS, and Sexually Transmitted Diseases received some mention in Strategies from 1999 through 2002, but disappeared entirely after 2002. After the 2000 Strategy, there are few or no references to incarceration.

Another criticism the Panel encountered concerning ONDP's National Drug Control Strategy was its heavy focus on a single, relatively narrowly-focused survey, *Monitoring the Future* (MTF), to describe the results of the Strategy -- this despite the availability of numerous diverse survey instruments and data sets regarding U.S. drug use. During the period 1999 through 2002, the Strategies used from 16 to 19 different data sets to support their content. However, most of these references disappeared in 2003, and, between that year and 2008, MTF, with its focus on 8^{th}, 10^{th}, and 12^{th} graders, commanded the majority of statistical references in the Strategy.

National Drug Control Budget

In addition to the National Drug Control Strategy, ONDCP compiles and publishes an annual National Drug Control Budget Summary. One of the key elements of the strategic planning process, as mentioned earlier, is that the resulting plan be based upon the resources that will be available to implement the plan. The Panel decided to conduct a detailed review of the Budget Summary because it has been the source of much controversy and is so central to ONDCP's mission.

In the words of one ONDCP official, the purpose of the Budget Summary is "to communicate to the world the extent of [federal] spending on the drug problem." However, the Budget Summary, in its current form, does not accomplish that purpose. Key budget elements of the National Drug Control Program are missing due to the restructuring of the National Drug Control Budget that was first announced by ONDCP in FY 2002 and carried out in FY 2004.

ONDCP officials describe the current Drug Control Budget Summary as displaying drug control funding, to the maximum extent possible, from identifiable line items in the Budget of the President or agency budget justifications. These line items are not requested by ONDCP, but by the various agencies in their own budget submissions and funded in their respective appropriations acts. Since the budget displays only identifiable line items, drug control costs that are embedded within non-drug line items or result from a part-time dedication of personnel and other resources are omitted. This is an important distinction since the majority of agencies performing drug control functions do not have drug control as their primary mission.

The FY 2002 Budget Summary, prior to the restructuring, included 57 drug agencies and programs and totaled $19.2 billion. The FY 2009 Budget Summary, by contrast, included only 26 drug agencies and programs totaling $14.1 billion. The omitted agencies are still conducting drug control activities, but those activities are not included in the Budget Summary and do not receive ONDCP budget oversight. Moreover, a careful review of the Budget Summary by Congress or the public would provide no indication that agencies such as the Forest Service and Park Service have extensive drug law enforcement activities, nor any insight into the activities of the Judiciary, the federal prison system or much of the drug control-related activity within the Department of Justice.

Under the Anti-Drug Abuse Act of 1988, ONDCP is required to review and certify in writing annually that each agency's drug control program budget request is adequate and contributes to the implementation of National Drug Control Strategy objectives. The 1998 ONDCP Reauthorization Act levied new budget oversight requirements on ONDCP and the drug control agencies that required agencies to submit accounting reports to ONDCP regarding their actual drug expenditures after review and attestation by their respective Inspectors General (IG). As a result, ONDCPs' accounting oversight workload increased dramatically.

In 2000, ONDCP commissioned the RAND Corporation to conduct a study of drug agency accounting because of concern over potential weaknesses in their methodology. RAND examined the drug cost estimating methodology for 10 agencies and concluded that problems existed in 7 of the 10 agencies and that corrective actions were needed so that the ONDCP Director could carry out his statutory review and certification responsibilities.

ONDCP cited the RAND study in its plan to restructure the drug control budget and based the plan on the "significant workload" involved in reviewing agency budgets and accounting reports and the desire to incorporate "results-oriented management." Further, the restructuring would exclude agencies with drug control activities that were incidental to their primary mission, agencies that mainly focused on consequences associated with the activities of other primary counterdrug agencies, and Treasury and Justice law enforcement agencies with primary missions that were not closely related to drug control.

The irony of the FY 2004 National Drug Control Budget restructuring that was carried out by ONDCP is that it did not markedly reduce ONDCP's responsibilities. Agencies that have drug control as the main part of their mission, e.g., The Drug Enforcement Administration and the National Institute of Drug Abuse, continued to be included in the Budget Summary and subject to ONDCP oversight, while the "softer" multi-mission drug control agencies, such as the Food and Drug Administration and the Forest Service, were omitted and excused from budget oversight. Notwithstanding the lack of budget oversight, the Panel found no evidence these agencies are shirking their drug control responsibilities or diverting funds intended for drug control.

The ONDCP Reauthorization Act of 2006 required that ONDCP return to a comprehensive National Drug Control Budget Summary. As of the FY 2009 Budget Summary, ONDCP had added a number of agencies in an appendix table titled, "Other Related Drug Control Funding by Agency," but had not yet returned to a comprehensive Budget Summary.

For many of the drug control agencies that have remained in the National Drug Control Budget Summary, the ONDCP budget oversight process has been a source of friction. A number of drug control partner agency officials voiced displeasure with the process and one senior Department-level official went as far as to object to the process citing Constitutional grounds. Some agencies have had to modify accounting systems to capture drug-related costs and Inspectors General have had to devote material human resources to examining and attesting to drug accounting reports.

Supply Reduction versus Demand Reduction

Historically, even predating the establishment of ONDCP, there has been tension between drug Supply Reduction and drug Demand Reduction proponents over the proper division of resources between those efforts. The decision as to the Supply/Demand split, of necessity, reflects Congressional direction and Administration policy prerogatives within the available funding. The National Drug Control Budget Summary has traditionally been split with Treatment and Prevention on the Demand Reduction side and Law Enforcement, Interdiction, and International programs on the Supply Reduction side.

Some critics of ONDCP have described it as having a bias toward Supply Reduction as evidenced by the greater portion of funds being directed toward those efforts. ONDCP has countered those critics by pointing out that the division between Supply and Demand efforts has created an artificial expectation of a 50/50 split and that Supply Reduction functions are inherently more expensive because they involve large capital outlays such as for military equipment and are broader in geographic scope.

The FY 2004 National Drug Control Budget restructuring by ONDCP also resulted in an adjustment in the Supply/Demand Split. Although the decrease in the total drug budget as a result of the restructuring was approximately 42 percent, Supply Reduction accounts were reduced by 53 percent, while Demand Reduction accounts were reduced by 17

percent. This action had the effect of resetting the Supply Reduction/Demand Reduction ratio from 67/33 in FY 2003 to 54/46 in FY 2004. However, the Supply Reduction accounts remaining after the restructuring have grown by $3.3 billion through the FY 2009 request while the remaining Demand Reduction accounts have decreased by $6 million.

A number of drug policy experts charge that two decades of supply reduction focus have failed to reduce the problem and favor a new approach emphasizing treatment. Although, according to several ONDCP officials, the Office still leans toward Supply Reduction programs, it is in agreement that treating heavily dependent users can reduce demand significantly and can help to undermine local drug markets and reduce the profitability of drug dealing. According to the 2007 National Drug Control Strategy, "Changing the behavior of the relatively small number of chronic drug users can have enormously beneficial consequences for society, not the least of which is to deprive illegal drug traffickers of their largest source of revenue—the addicted, frequent, high-volume drug user." The 2007 Strategy further states, "Healing drug users through effective treatment programs will lead to long-term reductions in drug profits which can shrink local drug markets to levels that can be more easily managed by local authorities."

Performance Measures

As explained earlier, GPRA requires agencies to submit strategic plans with a comprehensive mission statement, goals, and objectives, a description of how the goals will be achieved, a description of performance goals included in the plan, an identification of external risk factors, and a description of how programs will be evaluated. In compliance with GPRA, each of the drug control agencies, including ONDCP, produces a strategic plan. ONDCP is also required to develop and monitor performance measures for the partner drug control agencies.

The 1998 ONDCP Reauthorization Act required development of a Performance Measurement System to determine progress in achieving specific targets spelled out in the Act. In addition, the ONDCP Director was required to report to Congress regarding that system, to be designed in consultation with affected NDCP agencies and, among other things, identifying performance objectives, measures, and targets, to conform to NDCP agency budgets.

The Act essentially endorsed the ONDCP Program Measures of Effectiveness (PME) System that had been developed in 1997. The PME System applied a systems approach to the measurement of the impact of the National Drug Control Strategy's 5 goals and 31 objectives in three critical areas: reducing drug use, drug availability, and the consequences of drug use. These measures translated to 97 individual performance targets. However, the PME system reportedly implied a degree of granularity in the drug budget that did not exist. The 5 goals and 31 supporting objectives, although philosophically valid, could not be tied to line items in individual agency and program budgets.

Thus, in 2002, ONDCP replaced PME with the much simpler goals of two-year and five-year reductions in drug use. The difficulty is that these broad goals provide no means for measuring individual agency performance. To the extent that individual drug control agency efforts tie in to the annual National Drug Control Strategy, it is through their relationship to the Strategy's three national priorities of prevention; treatment; and supply reduction.

The Performance Section of recent National Drug Control Budget Summaries includes the various measures of drug control agency performance and the agency's most recent achievements against performance targets. However, this data in the Strategy is the result of Program Assessment Rating Tool (PART) reviews and GPRA measures and is a reiteration of data otherwise provided to OMB in connection with individual agency strategic planning processes. Although ONDCP makes reference to its Performance Measurement System, it does not have agency-focused measures tied directly to the Strategy. Since there are no agency-unique goals in the annual Strategy, there is nothing against which ONDCP can measure agency performance in support of the Strategy.

During the period FY 2003 through the FY 2009 request, ONDCP has requested and received an average of approximately $1.2 million per year for the development and improvement of performance measures. These funds have been used for a variety of initiatives, including determining price and purity of illicit drugs; marijuana yield assessments; improvements to the heroin signature and domestic monitoring programs; and a determination of law enforcement impact on cocaine availability. These initiatives are not focused on improving individual agency performance measures, but on general measures for determining the overall performance of the National Drug Control Program.

ONDCP's 2006 Reauthorization Act sets forth a series of new reporting requirements focusing on performance measurement for national drug control agencies. The Act tasks the Director to submit to Congress, as part of the National Drug Control Strategy, a description of a national drug control performance measurement system, that: 1) develops two-year and five-year performance measures and targets for each National Drug Control Strategy goal and objective; 2) describes the sources of information and data that will be used for each performance measure; 3) identifies major programs and activities of the NDCP agencies that support the goals and annual objectives of the National Drug Control Strategy; and 4) evaluates the contribution of demand reduction and supply reduction activities, as defined in the Act, and implemented by each NDCP agency in support of the National Drug Control Strategy.

In designing this performance measurement system, ONDCP can either merely repeat existing agency measures that are deeply embedded in individual agency strategic planning processes and are already monitored by OMB, overlay a new set of measures that increase agency reporting and potentially conflict with their individual strategic goals, or develop meaningful measures that inform policy-makers on the status of the nation's drug control efforts in the aggregate. The Panel preferred the latter approach.

The Road Ahead

Throughout the study, the Panel focused on whether current ONDCP management practices are maximizing efforts to combat the nation's drug problems and whether ONDCP is pursuing its mission to the fullest from a public health and law enforcement perspective. The Panel also considered whether the coordinating mechanisms for generating national drug policy are robust, how the responsibility for managing operational programs affects ONDCP's ability to coordinate effectively, and the appropriate balance between Congressional requests for information and ONDCP's ability to accomplish its mission. With regard to the National Drug Control Strategy, the Panel assessed how it has evolved over the past nine years, the extent to which partner agencies have input into its development and implementation, and whether it is a framework that conveys the magnitude of drug policy challenges and appropriate national responses. It is in this context that the Panel issued its recommendations:

Strategy - The Panel recommended that ONDCP develop a comprehensive multi-year National Drug Control Strategy, informed by high-quality and diverse datasets, covering all age groups, illicit drugs, and regions of the nation. ONDCP should bring to bear the full range of the nation's drug control expertise; build an internal culture that values critical inquiry, open debate, and pragmatic decision-making; engage academia and the workforce in developing a more creative and robust understanding of the nation's drug problem and drug threats; establish a working group of subject matter experts to advise ONDCP senior leadership on international, national, and regional/local drug issues; reinforce staffing for statistical analysis to compare and contrast relevant data sources and become the federal focal point for examination of the full range of drug-related data; and consider holding an annual conference to address issues raised by disparate data and perspectives.

Budget - The Panel recommendations in this area include that ONDCP develop a comprehensive National Drug Budget Summary, informed by a multi-year Strategy, that incorporates the total estimated federal expenditures for all supply reduction; demand reduction; state, local, and tribal affairs activities; and other federal activities related to drug control. The Panel further recommends that Congress modify ONDCP's oversight responsibilities relative to individual agency drug budgets. ONDCP should coordinate more closely with OMB in issuing its funding guidance and during the budget review process to ensure that its funding priorities are being considered; emphasize collaboration in assembling the drug control budget and use its budget review certification process sparingly; and emphasize the inclusion of all programs and costs in the National Drug Control Budget Summary as a useful policy tool, rather than calculating historical costs that can be attested to by Inspectors General;

Performance Measures – The Panel recommended that ONDCP no longer require drug control agencies to provide performance reports and corresponding Inspector General attestations that duplicate GPRA and PART data reported to OMB. The Panel believes that ONDCP's energies are better spent assisting agencies in improving the performance measures they report to OMB so that they align with the overall Strategy. In addition,

ONDCP should continue working on national measures that assess the aggregate performance in addressing the goals of the Strategy.

Collaborative and Consultative Culture - The Panel recommended that ONDCP work to create a more collaborative and consultative environment to increase its effectiveness in its relationships with Congress, the National Drug Control Program agencies, and stakeholders throughout the nation. ONDCP should comply with statutory requirements, or work with the Congressional committees to discuss and resolve disagreements regarding the impact and appropriateness of such requirements; provide information to Congress in a timely manner; schedule regular meetings with members and staff of the Authorizing and Appropriations Committees to improve communication and establish a more cooperative relationship; increase the NDCP agencies' ability to have meaningful input into the substance of the National Drug Control Strategy by establishing a more formal collaborative process; actively engage with NDCP agencies as they develop their drug control policies and collect appropriate data tied to their Strategy responsibilities; use Working/Coordinating Committees to expand its outreach capabilities; and institute a regular feedback mechanism with NDCP agencies and stakeholders.

Concluding Remarks

As ONDCP celebrates its twentieth year of existence, the Panel believes the organization has the opportunity to enhance its credibility and effectiveness, increase transparency, streamline its organization, simplify its work processes, bolster its workforce management, and improve and leverage its relationships. Seizing this opportunity will translate into increased organizational capacity to address the nation's drug challenges, with positive implications for the nation's public health. When Congress enacted legislation in 1988 to create ONDCP, it envisioned a policy and coordinating role that would harness the significant resources dedicated to address this multi-dimensional public health and law enforcement issue. The Panel believes that, as a mature organization, ONDCP must demonstrate its readiness, ability, and willingness to adapt to changing threats and realize its full potential.

Toward this end, the Panel has offered its findings and recommendations, rooted in the Panel and National Academy's abiding commitment to good government and to helping the nation combat drug abuse and its consequences. The Panel has worked assiduously to balance competing interests and to tailor its recommendations to ONDCP's particular mission challenges, especially the challenges it faces in coordinating across the federal spectrum. The Panel believes that ONDCP's timely implementation of the Panel's recommendations and associated action items will help ONDCP increase its organizational and mission effectiveness dramatically. In the process, ONDCP will enhance its capacity to marshal the nation's resources to accomplish its important mission.

Thank you. I would be happy to answer any questions you may have.

Mr. CUMMINGS. Thank you very much.
Dr. Carnevale.

STATEMENT OF JOHN CARNEVALE, PH.D.

Mr. CARNEVALE. Good afternoon, Mr. Chairman and members of the committee. I want to thank you for this opportunity to present my views on ONDCP's past performance, key actions, and recommendations to restore the integrity of that office, and the fiscal year 2010 National Drug Control Budget. I have a formal statement which I request be submitted for the record.

Mr. CUMMINGS. So ordered.

Mr. CARNEVALE. The committee asked me to discuss ONDCP's failures and its loss of status that occurred during the previous administration that could very well affect ONDCP's future effectiveness. I will highlight just a few of the findings I have in my written statement.

The first one is that ONDCP did not properly align the policy with the Federal drug control budget to implement it. In fact, policy and budget were exactly at odds with one another. The strategy essentially had one demand reduction goal, which was to reduce drug use among youth and adults, but had a budget that emphasized supply reduction.

Second, there was no accounting for the performance of that strategy. ONDCP ignored the congressionally mandated requirement for a systems approach to strategic planning, which includes performance accountability that looks at the effectiveness of policy. It instead relied on OMB's PART process that is program-oriented rather than policy-oriented.

No. 3, ONDCP jettisoned the statutorily required consultation process. Had it consulted and collaborated with external stakeholders, perhaps it would not have completely missed the meth and prescription drug epidemics.

Four, ONDCP failed to recognizing the softening of youth attitudes about the dangers of drug use that began in 2005. This new trend signals the very real possibility that youth drug use will now increase. Cutting prevention funding by 10 percent during the prior administration's tenure was wrong.

Five, ONDCP jettisoned much of the drug budget. Even though Congress required a comprehensive accounting of Federal drug control resources, billions of dollars in Federal drug control spending were ignored. This made it impossible for all of us to be smarter about drug policy decisionmaking.

So looking forward, what do we do to improve ONDCP's effectiveness? I have three recommendations, Mr. Chairman.

No. 1, ONDCP must meet its statutory obligation to take a systems approach to design the National Drug Control Policy. This systems approach is described in great detail in my written statement and is very much a part of the statutory authorization of ONDCP.

No. 2, ONDCP must heavily invest in demand reduction; in other words, prevention and treatment. This means preparing immediately for the possible resurgence in youth drug use and tackling addiction. More demand reduction will also eventually mean less

crime and violence for nations like Mexico as we reduce our long-term demand.

Three, with regard to the National Academy of Public Administration's recommendations, they did an outstanding job and they have a lot of great recommendations that I strongly support. However, there are two that I believe must be completely ignored, apologies to Dr. Christopher, please.

First, the Congress and administration should not implement the recommendation to essentially turn the budget process over to OMB. I worked in OMB in the 1980's and I remember what that process was like when we were in charge of the budget and there was no drug czar. We just witnessed in the fiscal 2010 budget what can go wrong when OMB is in charge of the National Drug Control Budget. We now have a policy-budget mismatch. Prevention is being cut at a time when it is most needed.

Second, the Congress and the administration should not accept NAPA's recommendation to also turn performance accountability over to OMB. NAPA's recommendation shows that it failed to recognize the critical difference between policy—excuse me, between program versus policy or strategy performance evaluation. ONDCP must rebuild a state-of-the-art performance accountability system along the lines of what it had in place in the late 1990's.

I want to conclude by briefly talking about the new administration's fiscal year 2010 budget request. It is my view that the new administration has gotten off on the wrong foot. I am disappointed by the proposed drug budget.

For example, the fiscal year 2010 drug budget continues cuts in prevention, particularly school-based prevention, and adds very little money for substance abuse treatment. This decision, presumably by the Office of Management and Budget, strengthens my point that the NAPA recommendation to essentially turn the budget decisions over to OMB is wrong. Again, let's not put OMB in charge of the drug budget.

This concludes my comments. Thank you for the opportunity to appear before you today. I am happy to answer any questions you may have.

[The prepared statement of Mr. Carnevale follows:]

Restoring the Integrity of the Office of National Drug Control Policy

Written Statement of:
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The Domestic Policy Subcommittee of The Committee on Oversight and Government Reform

Hearing on "*ONDCP's Fiscal Year 2010 National Drug Control Budget and the Policy Priorities of the Office of National Drug Control Policy under the New Administration.*"

May 19, 2009

Mr. Chairman, Ranking Member, and Members of the Subcommittee, it is indeed a great honor and privilege to submit testimony about the Office of National Drug Control Policy (ONDCP). ONDCP's mission is to lead the nation in setting a course to reduce illicit and illegal drug use and its damaging consequences. In achieving its mission, ONDCP is required to coordinate and collaborate with a multitude of federal agencies and other stakeholders that include state and local governments, non-government organizations, and other stakeholders to shape a national drug control strategy and a federal budget to implement it. This strategy is required to address the nation's needs with evidence-based programs, policies, and practices so that it can achieve its measurable short- and long-term goals and objectives. Recognizing that no one course of action may be perfect, the strategy is also required to include a performance measurement system to provide a feedback mechanism to act as a telltale about its success or failure. This feedback is essential to ensuring that the national strategy is self-correcting and flexible in its response to achieving its desired results and also responsive to dynamic circumstances.

ONDCP is the agency that can do much to save lives and mitigate crime and heath consequences associated with drug use. Its leadership is essential to the successful organization of a balanced, coordinated, and comprehensive national drug control strategy, one that can lead this nation and the international community out of the malaise that the drug problem creates. The new leadership now at ONDCP must restore ONDCP's prominence and effectiveness if the agency is to achieve its critical mission.

In my testimony below, I examine ONDCP's past performance relative to its statutorily designed mission. I find that it failed to achieve its mission in the last eight years and recommend a number of actions that might help restore ONDCP's integrity and effectiveness in guiding the nation through all the complex issues related to illicit drug use and its damaging consequences (the so-called drug problem). My testimony also incorporates the recent recommendations of the report by the National Academy of Public Administration (the NAPA Report) that examined ONDCP's capacity and performance in a similar regard. This report, "Office of National Drug

Control Policy, Building the Capacity to Address the Nation's Drug Problems" offers a series of recommendations, most of which I agree with and some with which I strongly disagree.[1] I will sprinkle in my thoughts on many of the NAPA recommendations throughout my testimony.

ONDCP's Past Performance

The drug policy of the past eight years had essentially one goal: to reduce youth and adult drug use by 10 percent in two years, by 2004, and by 25 percent in five years, by 2007. Unlike the strategies promulgated by past administration, the previous administration's national drug control strategy did not offer any goals related to reducing drug availability, nor did it offer any goals related to reducing the health and crime consequences directly related to drug use.[2] These critical outcome areas were ignored. The ONDCP reauthorization (and previous authorizations of that office) clearly requires goals in these areas.

So how did the past policy fare with regard to its goal of reducing drug use? I believe it is fair to say that the evidence is mixed. According to the National Survey on Drug Use and Health (NSDUH)—the annual survey of illicit and licit drug use provided each year by the HHS' Substance Abuse and Mental Health Services Administration—illicit drug use among adults (those persons ages 18 and older) remained unchanged since 2002. In 2002, drug use among those 18 years of age or older was 7.9 percent (16.6 million adult drug users). By 2007, it was 7.8 percent (17.4 million adult drug users). The strategy totally failed to achieve any progress in this key goal area established by the previous administration.

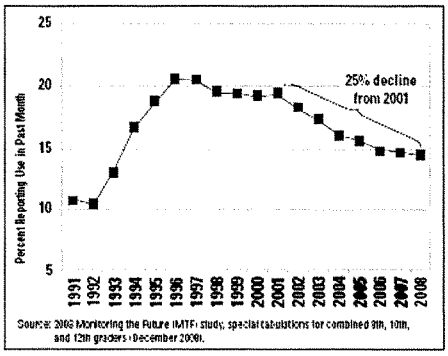
There was progress in reducing youth drug use. According to data Figure 1, in the January 2009 Strategy released by the previous administration, youth drug use as measured by the University of Michigan's Monitoring the Future Study (MTF) reported a 25 percent decline in drug use over

[1] The NAPA Report was required by the Congress to improve its oversight of ONDCP. The NAPA report was first published in November 2008.

[2] Drug strategies dating back to the Nixon Administration set performance targets to achieve results in the following three areas: drug use; drug use consequences, which would normally include targets related to drug-related health and crime matters; and drug availability. ONDCP statutorily mandate structure emphasizes supply reduction and demand reduction and lists numerous metrics that fall into these areas. Over the last eight years, ONDCP has targeted only one of these areas: drug use.

the 2002 to 2008 time period from a combined sample of 8th, 10th, and 12th graders. What ONDCP failed to note, but is depicted in the figure, is that this trend actually began after 1996. Past month use of any illicit drug among the combined sample of 8th, 10th, and 12th graders peaked in 1996 at 20.6 percent. By 2002 it had fallen by 11.7 percent to 18.2 percent, achieving half of the 1996 strategy's goal for 2002. The good news for the administration then in charge is that they not only stopped an upward trend in youth drug use that started in 1991, they were able to reverse it. They were, however, unable to achieve the five year goal of reducing youth drug use by 25 percent by 2002. Regardless, the fact that youth drug use declined starting in 1997 means those past efforts to reduce drug use had their foundation and roots in approaches launched within past strategies than within the current strategy. From 1996 to 2008, youth drug use as measured by this same survey fell by 29.1 percent; it fell by 24 percent more between 2001 and 2006, almost hitting the administration's five year goal of 25 percent. It did hit the 25 percent goal one year later in 2008 (see Figure 1).[3]

Figure 1.
Teen Drug Use is Down Sharply from 2001



It is important to note that in 2007 and 2008 youth attitudes about the dangers of drug use appear

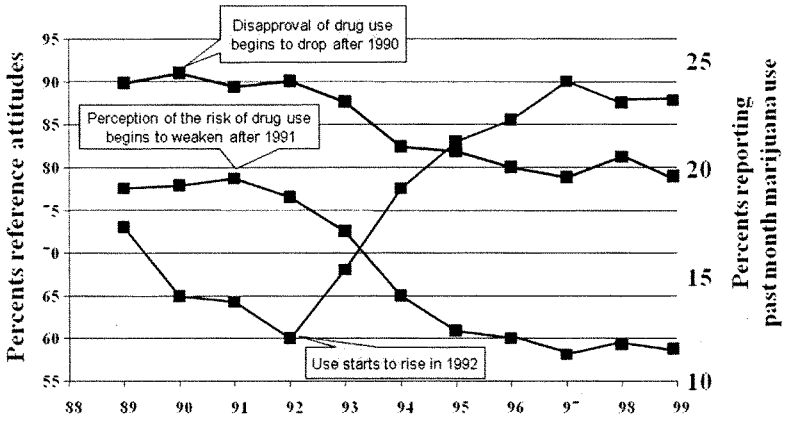
[3] The 1996 National Drug Control Strategy set a goal of reducing youth drug use by 25 percent by 2002. Using the past administration's own data, it is clear that the 1996 strategy was on track and achieved half its stated goal by 2002. Arguably, the reported success in this decade in reducing youth drug use is the result of past administrations efforts.

to be softening. According to the Monitoring the Future Study, the rate of disapproval of smoking marijuana regularly among youth in the 12th grade experienced a statistically significant decline between 2007 and 2008, from 83.3 percent to 79.6 percent.[4] In terms of how these same youth perceive the harmfulness of seeing others use marijuana on a regular basis, the rate also fell from 54.8 percent to 51.7 percent. Though this change was not statistically significant between 2007 and 2008, the decline in perception of harmfulness actually began in 2005, when it was at 58.0 percent—this decline (from 2005 to 2008) is statistically significant.[5] These changes in "softening" attitudes related to perceived harmfulness and disapproval of drug use do not bode well for the new Administration: it may well inherit a troubling upward trend of increasing youth drug use—with all its attendant problems and costs—if youth attitudes *continue* to soften. Indeed the new leadership could very well be blamed in the future for a serious problem that had its seeds planted well before taking office. As will be pointed out later, the previous administration cut resources for prevention substantially over its eight-year tenure. Perhaps these cuts are behind what now appears to be an emerging drug use problem among youth.

History can help us better understand the importance of these changes. Consider what happened to youth drug use back in 1992. Figure 2 shows that youth drug use spiked upward starting in 1992 when the Clinton administration entered office. The year 1992 represents a period when youth drug use was at its lowest point ever, but was preceded by a trend of a softening in attitudes about the dangers of drug use among youth. This softening in attitudes preceded the upward spike in youth drug use two to three years prior to the spike. No one foresaw this spike, nor was the prevention research field then a mature science as it is today, capable of foreseeing upward trends before they occur. In 1992 youth drug use was starting a five year upswing to almost record levels. If history repeats itself, the current Administration could soon face the same problem.

[4] University of Michigan, The Monitoring the Future Study, 2008, Table 10.
[5] Ibid, Table 7 and discussions with University of Michigan staff.

Figure 2
Relating Attitudes to Use



Source Monitoring the Future Study

In fact, a closer look at the 2007-2008 MTF data reveals an uptick in 8th and 12th grade past year use of any illicit drugs. These increases also occurred for past month use. Though not statistically significant, these trends must be watched closely. My advice to the new administration and the Congress is: hope for the best but wisely prepare for the worst. To prevent the worst case from occurring, resources for population-based prevention program efforts that incorporate environmental strategies as well as those that target high-risk youth must be immediately expanded.

As for progress in other critical drug use categories, the record is one of failure. New drug epidemics went largely ignored, despite warnings from many circles—particularly many individuals on this subcommittee. Abuse of prescription drugs exploded in this decade and

continues at what most epidemiologists would consider epidemic levels. And it is the same story for methamphetamine. Methamphetamine is an especially harmful drug; the number of individuals in treatment has doubled since 2000, thereby placing a serious strain on our limited treatment resources. The previous administration did eventually address these two areas, but only after the Congress intervened and directed it to do so.

Rates of addiction to illicit drugs (and to alcohol) remain unchanged. Why is this important? Research has shown that those who are addicted represent a small portion of the total drug using population, but are responsible for the majority of illicit drugs used each year and for much of the crime and societal harm that accompanies with drug use. In one study of cocaine, for example, it was found that those who were addicted represented about 20 percent of the population of cocaine users—a seemingly small group—but accounted for over two-thirds of all the cocaine consumed in the nation. Getting their numbers down makes sense as a goal for the national drug control strategy, not only because of the obvious health benefits, but because it means that those who traffic in cocaine will have a smaller drug market to serve. Those individuals on the front lines who try to prevent cocaine from entering the nation and being sold on its streets will have much less work to do if addiction can be reduced. Simply put: a smart demand reduction policy is a good supply reduction programming. It's simply common sense that applies to all drugs of abuse. Reduce demand and you will reduce supply.

As for other performance indicators, ONDCP reports that the potential production of heroin is up over the 2001 to 2005 period, mostly because of an explosion of poppy cultivation in Afghanistan. The exact estimate of heroin availability is unknown, as estimates for some nations are not available for certain minor heroin producing nations like Vietnam, Thailand, and Colombia. Estimates of potential production of cocaine hydrochloride for the 2002 to 2006 period show no change in the estimates. The estimate of 975 metric tons in 2002 is just five tons more than the estimate of 970 in 2006.[6]

[6]ONDCP National Drug Control Strategy Data Supplement 2009 (January 2009), tables 93 and 97.

With regard to measures of health consequences associated with drug use, the news is mixed. We know from research that some factors have a strong, established association to drug use and can serve as proxy measures for trends. For example, health statistics, such as HIV/AIDS rates, can provide insight into intravenous drug use (IDU) since that is a major method of disease transmission. From 2001 – 2006 (the latest year data are available), the bad news is that the number of males living with AIDS increased 37.8 percent from 261,224 to 353,825. However, the good news is that the percentage of these cases which are drug-related, meaning the percentage of the disease which was acquired through IDU, actually decreased from 30.9 percent in 2001 to 23.8 percent in 2006. In fact, the number of males who acquired AIDS through IDU continues a much longer downward trend that began in 1994. Similarly, the story is the same for females. The number of females living with AIDS has increased since 2001 from 71,089 to 131,195 (84%). During the same time period, the percentage who acquired the disease through IDU decreased from 38.2 percent in 2001 to 25.5 percent in 2006. Again, this recent success continues a much longer downward trend, which has been ongoing since 1994 when almost half (49.7%) of female AIDS cases were IDU-related.[7]

Crime is also a variable strongly correlated and associated with drug use. Aside from most substance use being a crime in itself, individuals commit crimes that are drug offenses, such as possession and trafficking: they commit crimes to obtain drugs directly or to obtain money to buy drugs, and they commit crime while under the influence of drugs. When reviewing crime trends from 2001 to 2007, it can be seen that the number of crimes reported to all law enforcement agencies has slightly decreased 5.25 percent overall from 11.87 million to 11.25 million. Property crimes, such as burglary, larceny-theft, motor vehicle theft, are more strongly associated with drug use than violent crimes (murder, rape, robbery, aggravated assault). Between 2001 and 2007, the number of property crimes decreased 5.7 percent from 10.43 million to 9.84 million. However, the number of individuals arrested for drug abuse violations, such as possession and/or drug sales increased 16 percent from 13.7 million in 2001 to 14.21 million in 2007. While the increase in arrests could reflect a change in enforcement policies, the

[7] ONDCP, Ibid, Table 35.

trend bears watching. Further, the percent of all arrests that drug-related arrests represent, increased from 11.5 percent in 2001 to 13.0 percent in 2007.[8]

In summary, except for progress in reducing youth drug use (which may now be ending), the previous administration failed to achieve results with regard to its goal for adult drug use or in key outcome areas. The NAPA Report found that ONDCP was "heavily reliant on data from a single survey, and [was] focused more on program success than comprehensively assessing the short- and long-term status of the drug problem."[9] Eight years were wasted.

Reasons for the Failure of ONDCP's Past Performance

There are many likely explanations about the failure of ONDCP to achieve its goals and to recognize and respond to emerging drug use trends. Chief among them is its failure to satisfy its statutory responsibility to engage its most critical role of coordinating and collaborating with other federal agencies, other levels of government, non-government organizations, and other experts in drug policy. This failure was compounded by other shortcomings, such as its inability to create a federal drug control budget to *match* the rhetoric of its strategy. It also failed to meet its statutory requirement to *evaluate* its strategy's progress using its own performance measurement system. It also failed to *recognize* the significant problems that our nation's seemingly insatiable demand for drugs creates for other nations. These problems and others are highlighted in the NAPA Report, but I will further elaborate on them here.

First, with regard to its responsibility to coordinate policy formulation—the drafting of the national drug control strategy that is responsive to the nation's drug problem—ONDCP acted almost in total isolation from its other stakeholders. One easy example of this is the disbanding of federal interagency working groups to manage and coordinate demand reduction and supply reduction policies, programs, and resources. To my knowledge, based on discussions with ONDCP and NAPA staff, such meetings were not held. This meant that those in the federal community involved in drug policy were not consulted for their ideas about how best to shape a

[8] ONDCP, Ibid, tables 39 and 40.
[9] NAPA Report, page xiii.

national evidence-based policy to address drug use and its consequences. In fact, the NAPA Report recommends that ONDCP "build a collaborative and consultative culture" with regard to external relationships.[10] The disbanding of the federal interagency working groups is only a single example, but a critical one.

Second, ONDCP managed to implement a federal drug control budget that was completely at odds with its one strategic goal of reducing drug use. As Table 1 shows, federal resources during the previous administration for supply reduction grew the most during the FY 02 to FY 08 period by 64 percent. In fact, supply reduction resources now represent nearly two-thirds of the total federal drug control budget. By comparison, resources for demand reduction grew by less than 9 percent and its share of total resources now represents just slightly more than one-third of all resources.

What drug control policy and funding approaches are truly *most* effective?? Research suggests that treatment and prevention programs are very effective in reducing drug demand, saving lives, and lessening health and crime consequences. It has demonstrated that attacking drugs at their source, by focusing on eradication, is expensive and not very effective. It has demonstrated that interdiction has little effect on drug traffickers' ability to bring drugs into the United States and on to our street corners where they are sold. It has also shown that law enforcement and the broader criminal justice system can be a powerful partner in using its coercive powers to help drug users stop using drugs and committing drug-related crime.

In budget terms, and considering the lessons offered by research, one would expect marginal changes in the drug budget emphasizing treatment, prevention, and law enforcement over source country programs and interdiction, yet the federal drug budget does not currently heed the evidenced-based course of action.

[10] NAPA Report, page xiv.

TABLE 1

Bush Administration Record on Federal Drug Control Spending, by Function FY 2002–FY 2009

(Budget Authority in Millions)

	FY 2002 Final	FY 2003 Final	FY 2004 Final	FY 2005 Final	FY 2006 Final	FY 2007 Final	FY 2008 Final	FY 2009 Enacted	FY 02 - FY 09 Dollar Change	FY 02 - FY 09 Percent Change
By Function:										
Treatment (w/Research)	$2,785	$2,876	$3,028	$3,053	$2,942	$3,061	$3,255	$3,416	$631.3	22.7%
Percent	*26.2%*	*25.9%*	*25.5%*	*24.1%*	*22.6%*	*22.1%*	*24.5%*	*23.0%*		
Prevention (w/Research)	$1,996	$1,937	$1,956	$1,952	$1,863	$1,842	$1,750	$1,791	-$205.0	-10.3%
Percent	*18.8%*	*17.5%*	*16.5%*	*15.4%*	*14.3%*	*13.3%*	*13.2%*	*12.1%*		
Domestic Law Enforcement	$2,867	$3,018	$3,190	$3,318	$3,475	$3,749	$3,544	$3,654	$786.7	27.4%
Percent	*26.9%*	*27.2%*	*26.9%*	*26.2%*	*26.7%*	*27.1%*	*26.7%*	*24.6%*		
Interdiction	$1,914	$2,148	$2,534	$2,928	$3,286	$3,176	$2,901	$3,836	$1,923	100.5%
Percent	*18.0%*	*19.4%*	*21.4%*	*23.2%*	*25.3%*	*22.9%*	*21.9%*	*25.8%*		
International	$1,085	$1,105	$1,159	$1,393	$1,435	$2,017	$1,825	$2,148	$1,063	98.0%
Percent	*10.2%*	*10.0%*	*9.8%*	*11.0%*	*11.0%*	*14.6%*	*13.7%*	*14.5%*		
Total	**$10,646**	**$11,083**	**$11,867**	**$12,644**	**$12,999**	**$13,844**	**$13,276**	**$14,845**	$4,199	39.4%
By Supply/Demand Split										
Supply	$5,865	$6,271	$6,883	$7,639	$8,195	$8,941	$8,270	$9,638	$3,772	64.3%
Percent	55.1%	56.6%	58.0%	60.4%	63.0%	64.6%	62.3%	64.9%		
Demand	$4,781	$4,813	$4,984	$5,005	$4,805	$4,903	$5,006	$5,207	$426	8.9%
Percent	44.9%	43.4%	42.0%	39.6%	37.0%	35.4%	37.7%	35.1%		
Total	**$10,646**	**$11,083**	**$11,867**	**$12,644**	**$12,999**	**$13,844**	**$13,276**	**$14,845**	$4,198	39.4%

Source: ONDCP Budget Summaries, 2003 through 2009. Trends and calculations by Carnevale Associates, LLC. May 2009.
Note: Budget estimates assume the drug budget accounting methodology used during the Bush Administration.

The previous table shows the following:

- Interdiction grew the most over the FY02-09 period, increasing by 101 percent, or $1,923 million, from about $1,914 million to $3,836 million.

- Source country resources grew the second fastest, by 98 percent, or $1,063 million, from $1,085 million to $2,148 million.

- Law enforcement grew the third fastest, increasing by 27 percent, or $786.7 million, over the period from $2,867 million to $3,654 million.

- Treatment places fourth place, increasing by 23 percent, or $631 million, from $2,785 million to $3,416 million.

- Prevention is dead last, with resources actually declining by 10 percent, or a negative $205 million, from $1,996 million to $ 1,791 million over the FY 02-09 period.

Given the past administration's emphasis on demand reduction, one would have expected exactly the opposite ordering of federal resources. Instead, compared to demand reduction resources, resources for supply reduction witnessed a nine-fold increase thereby creating budget/policy mismatch and likely contributing to ONDCP's poor performance in achieving results.

I am also concerned about the current administration's FY 2010 proposed budget with respect to its proposal to further cuts to prevention, particularly if the State Grants portion of Safe and Drug Free Schools and Communities is terminated. The requested increase for substance abuse treatment is too small to make much of a difference in reducing the demand for drugs. I hope our new drug czar who arrived too late to influence the FY 2010 budget request will make the expansion of resources for treatment and prevention much more of a priority in the out years to ensure the strategy's future success in reducing drug use and its consequences.

Third, ONDCP failed to meet the requirements of law by developing a performance measurement system linking the nation's actions to address the drug problem with its programs, policies, and practices enacted through the budget process. Rather than evaluating the performance of the strategy, ONDCP relied on the Office of Management and Budget Performance Assessment Rating Tool (PART).[11] PART, by its very design, looks at the effectiveness of individual programs; in this case, programs that are funded by the federal drug control budget. What PART fails to do is to evaluate the efficacy of the strategy's goals and objectives. In other words, one cannot use PART to evaluate whether the doubling of the interdiction budget over the course of the previous administration contributed in any way to results. PART may look at an individual interdiction program such as the DHS's Air and Marine Program, but this information alone is not sufficient to explain whether all interdiction programs are achieving their desired results. The same argument holds for the other four main ingredients of a drug strategy (prevention, treatment, law enforcement, and international efforts). ONDCP should have designed a system to provide a feedback mechanism to tell if the choice of programs, as reflected by its budget, was having any impact. Had it done so, perhaps we would not now be witness to the lack of progress in addressing this nation's drug problem.

The NAPA Report is not too keen on ONDCP engaging in performance measurement, as it views the OMB PART process as paralleling the requirement for performance measurement. In this regard, the NAPA Report is off the mark.[12] It recommends that ONDCP no longer require performance reports.[13] The problem with this recommendation is that the NAPA panel did not recognize the critical difference between program versus policy (strategy) evaluation. By law, ONDCP is required to assess the performance of its strategy, which means that it is to see if the mix of the five main ingredients of its strategy—prevention, treatment, law enforcement, interdiction, and international programs—is having the desired effect on achieving results in three key performance results areas—drug use, availability, and drug use consequences. PART

[11] It is my understanding that PART will be supplanted by another approach in the Obama administration.
[12] NAPA Report, page xv.
[13] NAPA Report, page 133.

is program based and is not an adequate tool to use to evaluate the efficacy of a drug policy. ONDCP must rebuild a state-of-the-art performance measurement system: such a system should at least match the level of sophistication of the former system in place in the late 1990's.[14]

Finally, by targeting interdiction and international programs, ONDCP was in essence taking the approach that supply reduction was the best way to reduce demand. Research suggests otherwise.[15] In fact, one prominent researcher has opined that such programs are designed to blame other nations' inabilities to curb cultivation and production for our own demand.[16] Blaming other nations for our own problems is not the solution for reducing our demand for drugs. In fact, one could argue the reverse: that it is our demand that is creating problems for other nations. The terrible drug-related violence now being experienced in Mexico is one clear and close example of the failure of our past drug control policy to reduce rates of addiction. As was stated earlier, our overall drug use—particularly rates of addiction—is the main reason that nations that are major supply contributors to the U.S. drug market have drug trafficking organizations fighting for the substantial profits brought about by the drug trade. I believe it is time for this nation to fully accept its responsibility for the role that its drug demand plays in fostering drug production, trafficking, and drug-related violence in other parts of the world.

ONDCP's Road to Recovery

Rather than to continue to dwell on ONDCP's failures, it is more useful and constructive to look ahead and discuss what is needed to create an effective national drug policy. The first step is to restore the ONDCP's integrity by recommitting the agency to its policy leadership mission. That Office was created by the Congress to focus this nation's efforts to solve the drug problem by developing and implementing a balanced, comprehensive national drug control strategy. To do

[14] For more information about the Performance Measurement System implemented by ONDCP in the 1990's, see Patrick Murphy and John Carnevale, "The Challenge of Developing Cross Agency Measures: A Case Study of the Office of National Drug Control Policy," The PricewaterhouseCoopers Endowment for the Business of Government, August 2001. The performance measurement system was endorsed by a "Sense of Congress" in ONDCP's 1998 reauthorization.

[15] RAND, Controlling Cocaine, 1992.

[16] See Peter Reuter, "Do No Harm: The Global Dimension of the War on Drugs Needs Downsizing," The American Interest • Volume IV, Number 4, Spring (March/April) 2009.

this, the ONDCP must, at the very minimum, restore and expand the critical coordination and collaboration efforts within the federal community, among all levels of government, as well as with non-governmental organizations. Only then can ONDCP effectively build consensus on how best to use law enforcement, the treatment and prevention communities, and international efforts to achieve measurable results in reducing drug use and its consequences.

When Congress first created ONDCP in 1988 (P.L. 100-690), it intended that ONDCP adopt a comprehensive approach to the formulation of the nation's effort to reduce drug use and its consequences. This included the requirement that ONDCP develop a comprehensive accounting of federal drug control spending. In FY 2004, ONDCP changed its budget accounting methodology by discarding what I and others such as NAPA consider essential agencies and programs that are drug-related. In the 2006 reauthorization of ONDCP, Congress stepped in to require ONDCP to comply with the requirement for a comprehensive accounting of federal drug control spending. ONDCP's budget document now includes a table in an appendix that includes resources for agencies that were discarded in FY 2004, but there is no explanation of what these agencies actually do with regard to helping the national drug control strategy achieve its goals and objectives. ONDCP must provide such an explanation if policymakers and stakeholders are to be informed about how the budget supports the strategy. A comprehensive accounting must be re-introduced and implemented. The NAPA Report also includes a similar recommendation.[17]

ONDCP is also required by law to run a budget formulation process for drug control spending which parallels what OMB does for the entire President's budget (drug and non-drug). Congress intended that ONDCP ensure that federal drug control agencies shape their budgets to reflect the President's drug control priorities as expressed in the national drug control strategy. The parallel process was intentionally designed by Congress to be independent of the OMB process to ensure the close nexus between policy and budget. This budget formulation role must remain part of ONDCP's core mission for reasons that are discussed below with regard to the systems approach

[17] NAPA Report, page 131.

that is implicit in the ONDCP authorization. With regard to this process, NAPA would jettison the requirement that ONDCP formulate the drug control budget using this independent, parallel process.[18] I disagree. If NAPA's recommendation were to stand, ONDCP would no longer review and certify departmental/bureau budgets, but would instead blindly rely on OMB to consider funding priorities. This would create a number of problems and complications, perhaps catastrophic and far-reaching ones, that could obviate the need for ONDCP:

- ONDCP would become completely reliant upon OMB to ensure that federal drug control funds are adequate to meet the needs of the strategy.

- Faced with competing priorities, OMB would not give the strategy adequate representation in the budget formulation process because of finite resources. In effect, the critical connecting "match" between policy and budget, so essential to efficacy, would be severed.

- Congress would no longer get the strong, executive office level advocacy for drug control resources that it envisioned when it created ONDCP.

ONDCP must re-establish its role in formulating the President's drug control budget to implement that policy and support it with a performance accountability system that can track the success of that policy.

Congressional Intent for a Systems Approach

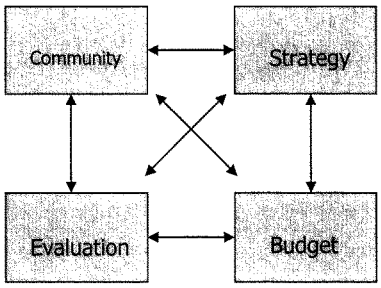
What is ultimately required to re-establish the efficacy of ONDCP is for the current administration to address what Congress intended when it created ONDCP: a systems approach to the formulation of the nation's drug control strategy. The systems approach that Congress ultimately enacted into law included a strong budget formulation role that has been continued and strengthened in each subsequent reauthorization of ONDCP. The systems approach is logic-

[18] NAPA Report, page 132.

based. It has been described in detail in a 2005 article.[19] It builds on a detailed, systemic, extensive needs assessment (sometimes called situational analysis) to determine the underlying problem or problems facing a community or nation. The needs assessment will include identifying the underlying drug problem, its costs, and existing government and non-government efforts to address that drug problem measured by such things like funding, operations, staffing, workload statistics, effectiveness measures, administration, support functions, existing evaluations/audits, and all other areas required by the final scope of services. It serves as a benchmark or baseline from which to begin the development of the strategic plan and to assess future progress.

The systems approach is intended to bring simple, practical solutions that stakeholders can effectively use to address the range of problems confronting their community. This approach results in an action-oriented, performance- and evidence-based strategic plan that is based in an environment that also includes the community, budget and resources, and performance evaluation.

This approach, as depicted in the following diagram, involves all stakeholders in the community coming together develop solutions reduce substance abuse, strengthen law enforcement, and ultimately promote healthy lifestyles.



[19] The systems approach is described in the study by Ronald Simeone, John Carnevale, and Annie Millar: "A Systems Approach to Performance Based Management: The National Drug Control Strategy," Public Administration Review, March/April 2005.

Community refers to stakeholders, or the constituent elements that have a stake in the pursuit to solve a particular drug problem. They get together in response to the drug problem. It is very important that the community of stakeholders truly represents everyone in the community who not only benefit from the outcome of a successful drug plan or strategy, but who may also be change agents (e.g., representatives from the government's budget office who are responsible for funding programs and operations). It is the community of stakeholders who conduct the original situation (or needs) assessment that defines the drug problem, which then becomes the basis of the strategic plan or strategy. It is in this area that ONDCP failed the most in the last eight years. The lack of coordination and collaboration as documented in the NAPA Report is the main reason why it "missed the boat" on emerging drug trends, linking the budget to the strategy, and representing the nation's interest in addressing the drug problem.

Strategy is the mechanism that allows goals and objectives to be pursued; it is an organized plan that strategically enables desires to become actionable items. It is important to remember that by definition a strategy or plan is nothing more than a document to guide decision making. Whenever an entity proposes a program, decision makers should refer to the guide first. Otherwise, the strategy will not be evidence-based. Strategy is the means by which the community of stakeholders addresses problems identified through their needs assessment. Congress intended a full consultative process in the formulation of the strategy. According to the NAPA Report, because of the failure to include all stakeholders in the consultative process, the strategy that emerged was no more than a plan unknown within the federal community and therefore unincorporated into federal agency drug control programs, policies, and practices.

Budget refers to the resources to implement the Strategy. It is the means by which actions identified by the strategy are funded and implemented. By design, Congress intended that the national drug control strategy be the driving force in shaping the national drug control budget. If ONDCP was reduced to merely its strategy formulation role, in other words, if it were no longer

required to push for federal resources to implement its strategy, then U.S drug policy would fail to achieve results. Policy must drive the budget process—as the Congress originally intended—for ONDCP to successfully engage the nation in reducing drug use and its consequences. NAPA recommends that ONDCP's budget role is duplicative of OMB's budget role. This view is absolutely wrong.

Evaluation is the feedback mechanism that informs the community of its progress in achieving its strategic goals and objectives. It is based on performance measurement. Evaluation includes an examination of the overall strategy or plan's ability to achieve its stated measureable goals and objectives. It also includes the examination of the very programs selected by the community of stakeholders to implement the strategy or plan. As was previously stated, ONDCP has relied on OMB's PART review to satisfy this requirement. The result was clearly unsatisfactory; the *lack of progress* in achieving the goal for reducing adult drug use and other areas related to addiction, drug availability, and health and crime consequences, *appears to have gone unnoticed.* Evaluation, when done properly, allows the community of stakeholders to make prompt, alert, and responsive corrective action in both the strategy and its budget.

This systems approach provides program and policy options for the community of stakeholders to implement evidence-based approaches. It also provides feedback with respect to outcomes or expected results. It also recognizes the importance of bottom-up input in promoting community-based behavioral change, is anchored in the latest knowledge about risk and protective factors, and provides a feedback mechanism to monitor results. The benefits derived from this particular systems approach often spill over into other policy areas, such as violence prevention. Ultimately, the use of this systems approach will result in a planning process that will ensure lasting results.

Fixing the Budget Formulation Process

The previous administration substantially changed how it accounts for federal drug control spending in two ways. First, in FY 2004, it dropped a number of federal agencies from its

accounting for federal drug control spending even though they were involved in drug control activities. By law, ONDCP is required to provide a full accounting of federal drug control spending. While drug control budget accounting may be an imprecise science, the changes introduced in FY 2004 lessened the ability of policy makers to understand how federal spending supports the national drug control strategy.[20]

Second, ONDCP substantially changed what is referred to in law as the budget certification process. Budget certification refers to a process by which ONDCP reviews each drug control agency's budget when it is submitted to OMB and states in writing whether that budget is adequate to achieve the goals and objectives of the President's national drug control strategy. Certification is a labor-intensive process. It once involved over fifty federal drug control agencies, which meant that ONDCP had to certify this many agencies in the fall. In theory, and under the law, by dropping drug control agencies from the budget formulation process, ONDCP could no longer attest to whether all federal agencies providing some form of drug control programming were acting in accordance with the requirements of the national drug control strategy.

I am repeating myself, but this is the crux of the systems approach. If ONDCP was to adopt NAPA's recommendation to modify the budget formulation process in which it works directly with OMB to establish annual funding priorities, the valuable certification process would be lost. The Government Accounting Office in 1999 reviewed and determined that "Certification allows ONDCP to influence agency drug budgets early in the budget development process and bring any drug budget shortfalls to the attention of budget decisionmakers."[21] In other words, certification had achieved what the Congress had intended with regard to shaping the federal drug control budget to effectively implement the national drug control strategy. Why NAPA would jettison this ONDCP's independent authority to represent the President's interest in

[20] For more information about the change in the methodology and its implications for policy, see the draft manuscript prepared by John Carnevale and Scott Chronister, "How Well Does the U.S. Drug Budget Match Policy and Program Realities?" February 2005.
[21] United State Government Accounting Office, "Drug Control: ONDCP's Efforts to Manage the National Drug Control Budget," May 1999 (GAO/GGD-99-80).

shaping the drug control budget through the certification process in the face of such evidence is an enigma. As for the road ahead, certification has its place as does the need for a comprehensive or full accounting of federal drug control spending. There are problems that must be corrected with regard to how some agencies estimate their spending for drug control, as was clearly delineated as far back as in the 1992 Rand Study.[22] ONDCP should implement the recommendation of that study to review and improve on an ongoing basis how agencies estimate their drug control spending when direct line items for drug spending are not included in their appropriations.

In thinking about how certification might be improved, it is possible that some changes could reduce ONDCP's workload without compromising its budget formulation role. What I am about to suggest is a *modified budget certification process* Built on the premise that not all drug control agencies are created equal when it comes to policy significance in the national drug control strategy. Federal drug control agencies like the Bureau of Prisons (BoP), which incarcerates over 50 percent of its population for drug-related crimes, cannot be considered an active policy participant in supporting the strategy. The strategy cannot set a goal calling for BoP to increase its percentage of the population in its prisons for drug-related reasons simply because it is at the back end of the criminal justice system. Increasing resources for investigations that lead to more arrests (say, by adding resources for DEA or FBI agents) can ultimately affect BoP's percentage. The drug budget should account for resources needed to incarcerate such persons, if for no other reason but to ensure that BoP can maintain its capacity to do so. For purposes of certification, therefore, BoP's budget should be reviewed to ensure that its drug accounting methodology is sound, but in such as case, not much more needs to be done. Continuing with this example, other agencies like the DEA and the FBI, which may be required by a national strategy to contribute more effort to investigations should be reviewed for purposes of certification.

To be more specific, I recommend that federal drug control agencies be divided into two tiers: those that are actively addressing policy needs and those that are not. Certification need only

[22] RAND, Improving Anti-Drug Budgeting, 2000.

occur once, in the fall when OMB is involved in the formulation of the President's budget. However, during the summer, ONDCP must review all budgets, but it would place emphasis on those budgets that are among the first tier. Summer budgets would receive letters stating that as formulation ONDCP intends to certify its request to ONDCP in the fall submission (assuming that they are in are in compliance with ONDCP drug budget directives issued in the Spring) and that it concurs with the drug budget methodology. Second tier agencies would be reviewed in the summer to see if their budget accounting methodologies are sound (which would also use the input from each agency's own Inspector General drug budget methodology reviews as currently required by law). What is most important is that OMB is made aware of ONDCP's views on the drug portion of an agency's budget and acts accordingly in the best interest of the national drug control strategy. ONDCP would retain its authority to appeal OMB's budget recommendations to the President, as it once did early in its history.

Another recommendation applies to how OMB manages the drug budget formulation process. Currently, the General Government Programs Division of OMB has the lead for coordinating internally all the budget examiners who oversee federal agency budgets that are designated by the Director of ONDCP as drug related. This Division has had this responsibility going back to the 1980's when drug policy focused heavily on drug interdiction and international programs. This division managed the Coast Guard, FBI, DEA, Customs, Border Patrol, the Secret Service, which were the primary agencies accounting for most of the resources in the drug control budget. This also made sense at the time because the national focus on drug policy heavily involved a criminal justice approach. Times have changed and so has the requirements for a sound, balanced, comprehensive drug control policy. Demand reduction now plays a greater role and that role will likely increase as the nation engages in health care reform, which will most assuredly move the federal government's drug policy more into the health care arena. Research into best practices and the science of addiction are also playing a much greater role. The point is: OMB needs to upgrade the standard of its coordination of drug policy to a higher level, one which effectively oversees and coordinates drug policy, not just from the division that is heavily focused on criminal justice matters, but to a more neutral position that balances demand

reduction and supply reduction budgets.

Emphasizing Demand Reduction

We know that drug demand in all its form is the heart of this nation's and other nations drug problems. Addiction is a chronic disease—but one that can be prevented, managed, and successfully treated. Taking the necessary steps to ensure that drug use is prevented to the maximum extent possible and that those who are addicted receive treatment is not only smart demand reduction policy, but is also exceedingly smart supply reduction policy precisely because it will reduce both the societal impact of that drug use and the amount of work required by our front line law enforcement and border security officers to stem the tide of drugs hitting our shores.

With regard to the road ahead, it is also important that the strategy again emphasize demand reduction and domestic law enforcement and place much less emphasis on interdiction and international programs. This is what research says works best in reducing drug use and its consequences. It is equally important that the budget be completely realigned to achieve the goals and objectives of the strategy. This means a complete and exact reversal of the budget priorities establish over the last eight years. It's time that we join together to more effectively address this nation's demand for drugs, not only to reduce human suffering, but also to alleviate the pressure on law enforcement and those who work day-in and day-out to target drug traffickers so that they might direct their energies elsewhere.

Recognizing Our Obligation to Help Our Nation's Warriors

Before closing, I want to take a moment to talk about our obligation as a nation to help returning warriors and veterans deal with the consequences of war-related trauma that may manifest itself in the form of substance abuse and addiction. According to national statistics, drug use is just one of many manifestations resulting from the trauma of war. The NSDUH shows that in 2003, an estimated 56.6 percent of veterans used alcohol in the past month compared with 50.8 percent of comparable nonveterans. An estimated 13.2 percent of veterans reported driving while under

the influence of alcohol or illicit drugs in the past year compared with 12.2 percent of comparable nonveterans. An estimated 18.8 percent of veterans reported that they smoked cigarettes daily in the past month compared with 14.3 percent of comparable nonveterans. Expectations are that the disparities among these various categories of use will worsen. As a nation, we owe it to these heroes—our nation's heroes—to provide the medical and behavioral health services they may now or will need to live healthy lives in their communities.

Conclusion

To be successful, the strategy must be firmly based on what research tells us is effective in reducing the demand and supply of illicit drugs. Drug policy should not be informed by personal opinion or ideology. Nor should it be supported by a drug budget that is completely at odds with what research says important to achieving the goals and objectives. It is time that drug policy support a much more balanced federal drug control budget—one that logically implements research-based programs to support and implement that Strategy. Ultimately, the so-called national drug control problem is the summation of a series of heterogeneous local drug problems. To be successful, the national strategy should promulgate programs and approaches that are evidence-based and flexible enough to enable each community to adapt programming to best meet their special circumstances.

A return to the proven success of demand reduction programs—treatment and prevention—and critical efforts to improve and expand those programs is what is most needed at this time to achieve progress on all fronts. We do know a lot about what works—for example, programs like the Drug-Free Communities Anti-drug Coalitions program, Safe and Drug Free Schools, Drug Courts, and the Weed and See, specialized treatment, and other locally-based programs—must be further developed and brought to scale. Local innovation must be encouraged. Efforts to foster collaboration among law enforcement at all levels—as best exemplified by the High Intensity Drug Trafficking Areas program—are known to be effective and must also be strengthened and expanded. Research to inform what we know about effective supply reduction and demand reduction programs as well as identifying the benefits from the use of medications

in support of treatment, health information technology, and substance abuse parity legislation must blossom. And efforts to unite the international community must also be included in any comprehensive strategy. We must become better partners with key international government and non-government bodies that coordinate global and western hemispheric drug control demand reduction and supply reduction efforts to learn about what works elsewhere. We must work to create a strong partnership with them to reduce the overall impact of drug use.

Finally, with regard to performance measurement, our nation's new drug czar, Gil Kerlikowske recently said it best in his confirmation hearing when he said that "if you can't measure it, you can't improve it."[23] He correctly noted that performance evaluation is critical to both validating and tracking the efficacy of the strategic goals and objectives and the individual programs that are funded to support it. A performance accountability system will enable everyone to be better able to report on our progress, justify the level of funding requested, and satisfy the interest of the citizens of this nation that their money is being well-spent and that their needs for a safer and more secure environment are being met.

I want to thank you again for the opportunity to appear before you today.

[23] Written statement of Chief Gil Kerlikowske before the Senate Judiciary Committee, April 1, 2009.

Mr. CUMMINGS. Thank you very much.
Mr. Reuter.

STATEMENT OF PETER REUTER

Mr. REUTER. Mr. Chairman, I appreciate the opportunity to testify before you this afternoon. I ask that my full statement, written with Jonathan Caulkins of Carnegie Mellon University, be entered into the record.

Mr. CUMMINGS. I can't hear you. I am sorry.

Mr. REUTER. I ask that my full statement, written with Jonathan Caulkins of Carnegie Mellon University, be entered into the record. Is this not coming through?

Mr. CUMMINGS. I can't hear him.

Mr. REUTER. Can I start over again?

Mr. KUCINICH. Just keep your voice up. It is not clear.

Mr. REUTER. Thanks.

Mr. Chairman, I appreciate the opportunity to testify. I ask that my full statement, written with Jonathan Caulkins of Carnegie Mellon University, be entered into the record.

Mr. CUMMINGS. Very well.

Mr. REUTER. Professor Caulkins and I address three issues in our testimony. First, we point to the importance of distinguishing among broad classes of drugs in making policy decisions. Much confusion results from treating all illegal drugs as a single policy target. For example, diverted pharmaceuticals present very different problems and policy opportunities than do cocaine and heroin.

In my oral testimony, though, I will focus mostly on our second issue, which is incarceration related to cocaine and heroin. I will just briefly discuss foreign policy issues.

The United States now has probably half a million individuals under lock and key for drug offenses on any given day, including the substantial numbers who are in local jails for drug charges. To put that in context, that is about 22 percent of the total prison population. It is more than the countries of the European Union with their 400 million citizens are able to put away for all criminal offenses. Even more to the point, it is 10 times as many as were imprisoned at the end of Ronald Reagan's administration when the drug problem was probably at its peak.

What has been the return for all this incarceration? The mechanism that links drug incarceration to drug use is price and availability. Tougher enforcement should make cocaine and heroin more expensive and less available. As is well-known, the purity adjusted price of cocaine and heroin have fallen steadily since 1981 when systematic measurement began.

According to a recent analysis done for ONDCP, the decline for cocaine continued even through 2007 even as the Mexican market descended into chaos. The availability measures based on population surveys have shown only modest declines for cocaine over that same period.

There probably has been a reduction in the number of regular users of cocaine and heroin over the last 20 years. However, that is more plausibly related simply to the working out of epidemics, cycles of fashion and culture, as indicated by the rapid aging of the cocaine and heroin dependent populations, though incarceration

certainly has had some modest effect on the numbers. Indicative of the aging, the share of those treated for heroin, cocaine, and methamphetamine dependence who are over 40 rose from just 13 percent in 1992 to 31 percent in 2004.

What if the Nation moved to a prosecution and sentencing regime that over the next few years reduced the number of drug prisoners to a mere quarter million? We believe that there is good analysis and argument that such a change would have minimal effect on drug price and availability. It would, however, save society substantial money and with appropriate alternative sanctions would also reduce the harshness with which the governments treat poor minority communities.

Any case for cutting drug imprisonment should not pretend that prisons are bulging with first-time nonviolent drug offenders. Most were involved in distributing drugs. Few got into prison on their first conviction. They had to work their way in. The system mostly locks up people who have caused a good deal of harm to society. Most will, when released, revert to drug use and crime. They do not tug the heartstrings as innocent victims of a repressive state. Nonetheless, locking them up should be the last resort, not an automated response.

Let me turn briefly to foreign policy issues. Two countries supply the United States with almost all its imported drugs, Colombia and Mexico. Afghanistan is the third country that matters not because its heroin reaches these shores in great quantities, but because the heroin industry helps keep the Taliban funded and also by financing warlords weakens essential government.

Again, the historical record and analysis both strongly suggests that there is little that can be accomplished to reduce the flow of drugs to the United States with interventions in other countries. Eradication and interdiction can affect how coca and opium are grown and the routes by which cocaine and heroin are trafficked. But the process of moving the industry around the world is quite damaging. What you produce for a transient country is likely to be hurt more than the original country benefits from a shift in the business. At a more micro-level, spreading coca growing to more parts of the Andes through intensive eradication efforts causes substantial harm to the ecology of the region. It is hard not to act against production and trafficking that hurts the United States, but we present arguments that such policies may cause more harm than good.

Thank you very much.

[The prepared statement of Mr. Reuter follows:]

Testimony

Of

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Co-Authored by

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(Not testifying)

Domestic Policy Subcommittee

Oversight and Government Reform Committee

Tuesday, May 19, 2009

2154 Rayburn HOB

2:00 p.m.

An Assessment of Drug Incarceration and Foreign Interventions

The new Director of ONDCP starts his tenure facing familiar challenges. Little has changed in the last eight years in either America's drug problems or in its drug policies. The problems have probably declined moderately, as the result of the working out of epidemiological factors. The number of persons incarcerated for drug selling has continued to rise, with no sign that this has reduced availability or increased prices.

It has become increasingly hard to justify the highly punitive nature of current U.S. policies, which contrast so sharply with other Western nations. A major accomplishment for the new administration would be to bring more rationality and humanity to sentencing policies and

enforcement. Though most of the incarceration is at the state level, the federal government plays a uniquely important role in the imprisonment of drug offenders, who account for approximately 60% of the 160,000 locked up in federal prisons. ONDCP should thus focus initially on ensuring that federal prisons are used more effectively for crime control. It can also attempt to educate state governments to move in the same direction and to develop ways of punishing drug sellers that are more effective, less expensive and more humane.

The United States also continues to invest in efforts to control production of cocaine and heroin. Though the sums are small as a share of the federal drug budget, they are large compared to other foreign aid efforts. Moreover, these interventions have minimal promise of helping reduce the availability of cocaine and heroin in the United States and risk considerable damage to other nations.

We address three issues in this testimony. First we point to the importance of distinguishing among broad classes of drugs in making policy decisions. Much confusion results from treating all illegal drugs as a single policy target. Second, we present the evidence and arguments for the claim that large reductions in the number of incarcerations for drug offenses would have minimal effect on the price and availability of drugs. Finally, we address the reasons for skepticism that efforts in producer countries will reduce the availability of cocaine and heroin in the United States and argue for doing much less overseas.

I. Different drugs present different challenges

To understand almost anything about the effectiveness of US drug policy it is first essential to distinguish between four categories of illegal drugs: (1) diverted pharmaceuticals, (2) all the minor illegal drugs (PCP, GHB, LSD, etc.): (3) the major "expensive" illegal drugs (cocaine/crack, heroin, and meth(amphetamine), and (4) cannabis.

Diverted pharmaceuticals are an increasingly important topic because they account for an astonishing share of drug-related overdoses, use by youth, and prevalence in the general population[1]. However, their ill-effects are largely confined to the users e.g., there is little black market violence or property crime. They deserve their own separate analysis, because the options for interventions are so different than those relevant for the purely illicit drugs. We say nothing more about them here.

[1] See e.g. Compton, W.M. and Volkow, N.D. (2006). "Major Increases in Opioid Analgesic Abuse in the United States: Concerns and Strategies." Drug and Alcohol Dependence, 81(2): 103-107.

The minor illegal drugs represent no great challenge to policy. They are minor because of some combination of their intrinsically limited appeal and/or the success of current policies. Use and use-related harms are low. The markets are largely social rather than commercial, thus generating few problems. Enforcing the prohibition imposes few costs. The only serious critics of the status quo are those who believe that certain hallucinogens can yield benefits to users that are foregone because of the prohibition. That is almost certainly a political non-starter, and we do not in any event believe the putative benefits are yet sufficiently documented to warrant the risk inherent in any change in policy.

The drugs that matter most are the "majors", but it is essential to distinguish between cannabis on the one hand, and the "expensive" illegal drugs on the other. Little one can learn or say about cannabis applies to the other drugs, and vice versa. A substantial proportion of the misinformation surrounding drug policy comes from not respecting those differences.

The differences are in part "medical". Marijuana is by no means harmless.[2] Multiple millions of Americans are dependent on marijuana and no other illegal drug, and that dependence harms health and impairs adolescent development, job performance and social interactions.[3] However, not all types of dependence are the same. To make the point with an extreme example, it is possible to define such a thing as caffeine dependence, but caffeine dependence has minimal adverse effect on one's ability to function. We are not equating marijuana dependence with caffeine dependence. Marijuana dependence is clearly much more debilitating. But it is also important not to equate marijuana dependence with crack dependence. Crack dependence is clearly much more debilitating.[4]

The differences between marijuana and the expensive illegal drugs go far beyond the medical. Notably, cannabis is so inexpensive, indeed competitive with alcohol in terms of the cost of an hour of an altered state of mind, that the associated black market generates far fewer problems. There are few drive-by shootings associated with marijuana. There is some evidence that marijuana use can stimulate "economic-compulsive" crime as users seek to finance their

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[2] For a recent review of the effects of marijuana on health, see Chapter 2 of Room, Fischer, Hall, Lenton and Reuter (2008) Cannabis Policy: Moving beyond the Stalemate http://www.beckleyfoundation.org/pdf/BF_Cannabis_Commission_Report.pdf [accessed December 11, 2008]

[3] NSDUH Report on Daily Marijuana Users http://www.oas.samhsa.gov/2k4/dailyMJ/dailyMJ.pdf

[4] For a study of differences in the consequences of dependent use see Nutt, D., King, L.A., Saulsbury, W. & Blakemore, C. (2007). Development of a rational scale to assess the harm of drugs of potential misuse. Lancet, 369: 1047-1053.

marijuana habit, but the amount of such crime – particularly on a per user basis – is smaller by orders of magnitude than the corresponding problem with the expensive illegal drugs.

It is also not possible to ignore the simple fact that cannabis is widely used, whereas only a few percent of Americans use any of the expensive major illegal drugs beyond some experimentation. It is worth noting that this statement is true of most Western nations.

We will lay out a framework for thinking about what constitutes effective drug policy for the major expensive illegal drugs because they collectively account for close to 90% of the social costs associated with the purely illegal drugs; cannabis though more widely used is simply not where the big problems are, and it too merits a separate analysis.

The Expensive Illegal Drugs

There are four important things to recognize about cocaine/crack, heroin, and the amphetamines, particularly methamphetamine, which we abbreviate collectively as meth(amphetamine). First, prohibition has made them vastly more expensive than they would be if they were legal. Second, those high prices, along with the absence of promotion and uncertainty about quality, reduce use. Third, the markets for and use of these drugs are sufficiently established that they should be viewed as endemic, offering little practical prospect of elimination. Fourth, although prohibition plus high prices greatly reduce the number of users, including the number of dependent users, they increase the harm suffered by those who do become dependent and the amount of damage each of them causes the rest of society.

The first two points collectively constitute the practical argument for prohibiting these drugs. The difficulty is to balance them against the fourth point, namely the unintended, though often predictable, harms caused by tough efforts to enforce prohibition.[5]

Given that these drugs, or any particular drug, are going to be prohibited, the question becomes what form should that prohibition take? Ideally the prohibition would leave only a tiny market, such as what we have with GHB or PCP. So, one option is to pursue a prohibition so aggressive as to drive the market for one or more of these expensive major drugs down to de minimus levels. Arguably that has been the central theme of US drug policy for the last 25 years, and the results are not encouraging. At least in a free society, it does not appear feasible to

[5] For a recent essay on the sources of unintended consequences see Reuter , P. (2009) "The Uninended Consequences of Drug Policy" http://www.rand.org/pubs/technical_reports/2009/RAND_TR706.pdf

put the genie back in the bottle. Borders are too porous. The drugs themselves are too easy to produce, and they are too potent (meaning the quantities involved are too easy to conceal).

The policy analytic jargon for this is that it is prohibitively expensive to "tip" the markets from the current equilibrium down to an equilibrium in which their market's size (measured in, say, doses consumed in the US per year) is similar to that of GHB. That is why we say that we must view cocaine/crack, heroin, and meth(amphetamines) as endemic.

That these drugs are endemic, however, does not mean that they need be prevalent, the way marijuana is. Slightly more than half of recent birth cohorts in the US have or will at some point try marijuana. Arguably, trying marijuana at least once (as opposed to using it on an ongoing basis) has become normative, and lifetime abstinence is actually slightly less common. In California, marijuana is sold openly in medical marijuana shops to people with the flimsiest of documentations of medical need.[6] Throughout the country, marijuana users are arrested at startling high rates, but very few are convicted and incarcerated.[7] Marijuana use has entered a grey area of stigmatization. It is not OK, but it's also not so bad in the eyes of many.

A very important goal for drug policy is not to have use of any of the major expensive illegal drugs become comparably normalized. They are all potent substances that kill and create dependence from which people often never fully recover. Long-term follow studies of people in heroin treatment show that after 33 years, the most common way of becoming abstinent is to die.[8]

The essential policy questions then become, (1) How much "toughness" is enough to keep an endemic drug from becoming quasi-normalized and (2) How does one make endemic use under prohibition as minimally destructive as possible. The short answers to these questions are that we only need perhaps one-half of the current level of toughness and that at the broad ends of the drug distribution system's double funnel, one should balance drug *control* objectives with the control of other drug-related problems.

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[6] For a description of the current state of the marijuana situation in California see Samuels, D. (2008). Dr. Kush: How medical marijuana is transforming the pot industry. New Yorker, July 28. http://www.newyorker.com/reporting/2008/07/28/080728fa_fact_samuels

[7] The only study that we are aware of concerning the sentences of marijuana possession cases in the U.S. covers three large counties in Maryland in the late 1990s. O(f those arrested for marijuana possession almost none received a sentence of jail, let alone state prison, but one third spent at least one nigh in jail in pretrial detention. Reuter, P., Hirschfield, P. & Davies, K. (2001). Assessing the Crackdown on Marijuana in Maryland. unpublished paper, U. of Maryland. http://www.drugpolicy.org/docUploads/md_mj_crackdown.pdf

[8] Hser, Yi-Ing , V. Hoffman, C. E. Grella, and M. Douglas Anglin. 2001. "A 33 year follow-up of narcotics addicts." Archives of General Psychiatry 58 (5): 503–508.

II. Excessive Drug Incarceration[9]

The United States may have surpassed the half-million mark for drug prisoners, which is more than 10 times as many as in 1980.[10] It is an extraordinary number, more than Western Europe locks up for all criminal offenses combined. How effective is this level of imprisonment in controlling drug problems? Could we get by with, say, just a quarter million locked up for drug violations?

Tough enforcement is supposed to drive up prices and make it more difficult to obtain drugs, and thus reduce overall drug use and the problems that it causes.[11] Yet the evidence indicates that quite limited success at reducing the supply of established mass-market drugs. Thus, even assuming that tough enforcement was an appropriate response at an earlier time, today's situation justifies considering different policy options.

Most U.S. drug efforts go to enforcing drug laws, predominantly against sellers; oddly enough, that is also true for other less punitive nations, including the Netherlands.[12] Although eradication and crop substitution programs overseas in the source countries, primarily in the Andes, get a lot of press coverage, they account for a small share of even the federal enforcement budget, about $1 billion. More money—about $2.5 billion in 2004—is spent on interdiction: trying to seize drugs and couriers on their way into the country. The bulk of U.S. expenditures go toward the apprehension, prosecution and incarceration of drug dealers within our borders.

The great majority of those locked up are involved in drug distribution. Although a sizable minority were convicted of a drug possession charge, in confidential interviews most of them report playing some (perhaps minor) role in drug distribution; for example, they were couriers transporting (and hence possessing) large quantities or they pled down to a simple possession charge to avoid a trial.[13]

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[9] This section is adapted from Caulkins, J. and Reuter (2006) "Re-orienting Drug Policy" Issues in Science and Technology 23(1)

[10] Caulkins, J. P. and S.Chandler (2006) Long-Run Trends in Incarceration of Drug Offenders in the US. Crime and Delinquency. Vol 52, No. 4, pp.619-641

[11] Reuter, P. & M. Kleiman (1986) "Risks and Prices: An Economic Analysis of Drug Enforcement," Crime and Justice: An Annual Review 9, pp.128-179.

[12] Rigter, H. (2006) What drug policies cost. Drug policy expenditures in the Netherlands, 2003.Addiction 101, 323–329.

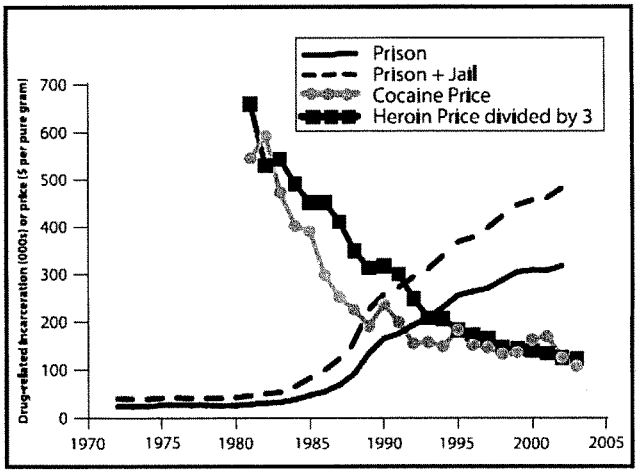
[13] Sevigny, Eric and Jonathan P. Caulkins. 2004. "Kingpins or Mules? An Analysis of Drug Offenders Incarcerated in Federal and State Prisons." Criminology and Public Policy, Vol. 3, No. 3, pp.401-434.

Society locks up drug suppliers for multiple reasons. Drug sellers cause great harm because of the addiction they facilitate and the crime and disorder that their markets cause. Thus there is a retributive purpose for the imprisonment. Still, sentences can exceed what mere retribution might require. Perhaps the most infamous example was when the possession of 5 grams of crack cocaine generated a five-year mandatory minimum sentence, compared with a national average time served for homicide of about five years and four months, even though that $400 worth of crack is just one fifty-millionth of U.S. annual cocaine consumption, or about two weeks' supply for one regular user.

Does tough enforcement work?

An important justification for aggressive punishment is the claim that high rates of incarceration will reduce drug use and related problems. The theory is that tough enforcement will raise the risk of drug selling. Some dealers will drop out of the business, and the remainder will require higher compensation for taking greater risks. Hence the price of drugs should rise. It should also make drug dealers more cautious and thus make it harder for customers to find them. So the central question is whether the huge increase in incarceration over the past 25 years has made drugs more expensive and/or less available.

U.S. Drug-Related Incarceration and Retail Heroin and Cocaine Prices



The science of tracking trends in illicit drug prices is not for purists; there are no random samples of drug sellers or transactions. However, the broad trends apparent in the largest data sets (those stemming from law enforcement's undercover drug buys[14]) are confirmed by other sources, including ethnographic studies, interviews with or wire taps of dealers, and forensic analysis of the quantity of pure drug contained in packages that sell for standardized retail amounts (for example, $10 "dime bags" of heroin). During the past 25 years, the general price trends have gone more or less in the opposite direction from what would be expected (see figure). Incarceration for drug law violations (primarily pertaining to cocaine and heroin) increased 11-fold between 1980 and 2002, yet purity-adjusted cocaine and heroin prices fell by 80%. Methamphetamine prices also fell by more than 50%, although the decline was interrupted by some notable spikes. Marijuana prices unadjusted for purity rose during the 1980s and 2000s but fell during the 1990s. Declining prices in the face of higher incarceration rates does not per se contradict the presumption that tougher enforcement can reduce use by driving up prices. Other factors may have driven the price declines. Drug distributors might have been making supernormal profits in the early 1980s that were driven out over time by competition, or "learning by doing" might have improved distribution efficiency within the supply chain. Hence, it is possible that prices would have fallen still farther had it not been for the great expansion in drug law enforcement.

One study of this question found that cocaine prices in 1995 were 5 to 15% higher as a result of the increases in drug punishment since 1985.[15] That result helps save the economic logic that supply control ought to drive retail prices up, not down, but the estimated slope of the price-versus-incarceration curve is so flat that expanded incarceration appears not to have been a cost-effective tool for controlling drug use.

During that 10-year period, incarceration for drug law violations increased from 82,000 to 376,000, about two-thirds of which were cocaine offenders (roughly 200,000). Thus, to achieve the modest increase in cocaine prices, it cost an extra $6 billion a year just for incarceration (assuming a cost of $30,000 per year to house an inmate). Annual cocaine

[14] For a discussion of the STRIDE (System To Retrieve In formation from Drug Evidence) see Manski, C., Pepper, J. and C. Petrie (eds.) (2001) Informing America's Policy on Illegal Drugs:What We Don't Know can Hurt us. Washington, National Academy Press

[15] Kuziemko, I. and Levitt, S. (2004). "An Empirical Analysis of Imprisoning Drug Offenders." Journal of Public Economics. 88(9-10):2043-2066.

consumption then was about 300 metric tons. So even assuming an elasticity of demand as large, in absolute value, as –1, a 10% increase in price would avert only about 30 metric tons of consumption, or less than 5 kilograms per million taxpayer dollars spent on incarceration. That cost-effectiveness ratio compares very unfavorably with those RAND's Drug Policy Research Center has estimated for demand-side interventions.[16]

Nor is there any evidence that tougher enforcement has made cocaine or other drugs harder to get. The fraction of high-school seniors reporting that cocaine is available or readily available has been about 50% for 25 years; for 85% of respondents, the same statement remains true for marijuana.[17]

Changing times, changing policies

With a few exceptions (notably oxycontin and methamphetamine), the drug problem in the United States has been slowly improving during the past 15 years. The number of people dependent on expensive drugs (cocaine, heroin, and methamphetamine) has declined from roughly 5.1 million in 1988 to perhaps 3.8 million in 2000, the most recent year for which figures have been released. The residual drug-dependent populations are getting older; more than 50% of cocaine-related emergency department admissions are now of people over 35, compared to 20% 20 years ago.[18] The share of those treated for heroin, cocaine, and amphetamine dependence who were over 40 rose from 13% in 1992 to 31% in 2004. Kids who started using marijuana in the late 1990s are less likely to go on to use hard drugs than were kids who started in the 1970s.

What we face now is not the problem of an explosive drug epidemic, the kind that scared the country in the 1980s when crack emerged and street markets proliferated, but rather "endemic" drug use, with stable numbers of new users each year. The substantial number of aging drug abusers cause great damage to society and to themselves, but the problem is not

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[16] Rydell, C. Peter, Jonathan P. Caulkins, and Susan Everingham. 1996. "Enforcement or Treatment: Modeling the Relative Efficacy of Alternatives for Controlling Cocaine," Operations Research, Vol. 44, No. 5, pp.687-695.

[17] See the annual reports of Monitoring the Future Johnston, Lloyd D., Patrick M. O'Malley, and Jerald G. Bachman. (2008). Monitoring the Future national survey results on drug use, 1975-2002. Volume I: Secondary school students Bethesda, MD: National Institute on Drug Abuse.

[18] Trunzo, D, Henderson L, (2007) Older Adult Admissions to Substance Abuse Treatment: Findings from Treatment Episode Data System 1992-2005 Presentation to American Public Health Association annual meetings, November 6

rapidly growing. Rather, it is slowly ebbing down to a steady state that, depending on the measure one prefers (quantity, expenditure, number of frequent users), may be on the order of half its peak.

Rising imprisonment probably made some contribution to these trends. Some of the most aggressive dealers are now behind bars; their replacements are no angels but may be both less violent and less skilled at the business. However, the discussion above raises doubts about whether incarceration accounts for much of the decline. If prices have not risen and if the drugs are just as available as before, then it is hard to see how tough enforcement against suppliers can be what explains the ends of the epidemics and the gradual but important declines in the number of people dependent on expensive drugs.

Moreover there is an opportunity learn from the experience of other countries. For example both the Netherlands and Switzerland, which have much less punitive policies with respect to heroin, have also seen long-term slow declines in the size of their heroin dependent populations.[19] For cocaine, no other country has a large problem from long ago to allow comparison.

The declines provide an opportunity. Changed circumstances justify changed policies, but U.S. drug policies have changed only marginally as the problem has transformed. The inertia can be seen by examining why the number of prisoners keeps rising even as drug markets get smaller. Drug arrests have been almost flat at 1.6 million a year for 10 years, and more and more of them are for marijuana possession (almost half in 2007), which produces very few prison sentences.

Three factors drive the rise in incarceration. First, today's drug offenders are not just older; they also have longer criminal records, exposing them to harsher sentences. Second, legal changes have made it more likely that someone arrested for drug selling will get a jail or prison sentence. Third, the declining use of parole has meant longer stays in prison for a given sentence length. On average, drug offenders who received prison sentences in state courts in 2002 were given terms of four years, of which they served about half. Is it a good thing that those being convicted are now spending more time behind bars?

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[19] For Switzerland see Nordt, C., and R.Stohler. 2006. "Incidence of Heroin Use in Zurich, Switzerland: A Treatment Case Register Analysis." The Lancet 367(9525): 1830–1834.

Any case for cutting drug imprisonment should not pretend that prisons are bulging with first-time, nonviolent drug offenders. Most were involved in distributing drugs, and few got into prison on their first conviction; they had to work their way in. The system mostly locks up people who have caused a good deal of harm to society. Most will, when released, revert to drug use and crime. They do not tug the heart strings as innocent victims of a repressive state.

Still, would the United States really be worse off if it contented itself with 250,000 rather than 500,000 drug prisoners? This would hardly be going soft on drugs. It would still be a lot tougher than the Reagan administration ever was. It would ensure that the United States still maintained a comfortable lead over any other Western nation in its toughness toward drug dealers. Furthermore, incarcerating fewer total prisoners need not mean that they all get out earlier. The minority who are very violent or unusually dangerous in other ways may be getting appropriate sentences, and with less pressure on prison space, they might serve more of their sentences. Deemphasizing sheer quantity of drug incarceration could usefully be complemented by greater efforts to target that incarceration more effectively.

There is no magic formula behind this suggestion to halve drug incarceration as opposed to cutting it by one-third or two-thirds. The point is simply that dramatic reductions in incarceration are possible without entering uncharted waters of permissiveness, and the expansion to today's unprecedented levels of incarceration seems to have made little contribution to the reduction in U.S. drug problems.

Drug treatment as an alternative to incarceration has become a standard response, more talked about than implemented. Drug courts that use judges to cajole and compel offenders to enter and remain in treatment are one tool, but they account for a very small fraction of drug-involved offenders because the screening criteria are restrictive, excluding those with long records.[20] Proposition 36 in California, which ensured that most of those arrested for drug possession for the first time were not incarcerated, seems to have been reasonably successful in at least cutting the number jailed without raising crime rates or any other indicator one worries

[20] Bhati, A., Roman, J. and A. Chalfin (2008) To Treat or Not to Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders The Urban Institute http://www.urban.org/publications/411645.html [accessed November 15, 2008

about.[21] These, though, are interventions that deal with less serious offenders, most of whom will only go to local jail rather than to prison.

A more important change would be to impose shorter sentences and then use University of California at Los Angeles Professor Mark Kleiman's innovation of coerced abstinence as a way of keeping them reasonably clean while on parole.[22] Coerced abstinence simply means that the criminal justice system does what the citizens assume it is doing already, namely detecting drug use early via frequent drug testing and providing short and immediate sanctions when the probationer or parolee tests positive. The small amount of research on this kind of program suggests that it works as designed, but it is hard to implement and needs to be tested in tougher populations, such as released parolees.

A democracy should be reluctant to deprive its citizens of liberty, a reluctance reinforced by the facts that imprisonment falls disproportionately on poor minority communities and that many U.S. prisons are nasty and brutalizing institutions. Further, there is growing evidence that the high incarceration rates have serious consequences for communities. A recent study suggests that differences in black and white incarceration rates may explain most of the sevenfold higher rate of HIV among black males as compared to white males.[23] If locking up typical dealers for two years rather than one has minimal effect on the availability and use of dangerous drugs, then a freedom-loving society should be reluctant to do it.

Yet we are left with an enforcement system that runs on automatic, locking up increasing numbers on a faded rationale despite the high economic and social costs of incarceration and its apparently quite modest effects on drug use. The continuing rise in numbers is particularly striking because it is likely that the number of offenses and offenders has actually declined. Truly "solving" the nation's drug problem, with its multiple causes, is beyond the reach of any existing intervention or strategy. But that should not prevent decisionmakers from realizing that money can be saved and justice improved by simply cutting in half the number of people locked up for drug offenses.

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[21] Fratello, D. (2006). Proposition 36: Improving Lives, Delivering Results - A review of the first four years of California's Substance Abuse and Crime Prevention Act of 2000. San Francisco: Drug Policy Alliance.
[22] Kleiman,M 1997. "Coerced abstinence: A neopaternalist drug policy initiative," In The New Paternalism: Supervisory Approaches to Poverty, ed. Lawrence M. Mead, 182–219. Washington, DC: Brookings Institution.

[23] Johnson, R. and Raphael S. (2006). "The Effects of Male Incarceration Dynamics on AIDS Infection Rates among African-American Women and Men" http://www.law.berkeley.edu/files/johnson_raphael_prison-AIDSpaper6-06.pdf

III. Foreign Ventures[24]

Both history and argument show that U.S. international efforts to control drug production and trafficking cannot do much more than affect where and how coca and opium poppies are grown. The quantity produced is minimally affected, since suppression of production in one country almost invariably leads to expansion in another.

More important, control efforts often cause damage. Not only are such programs as spraying poppy and coca fields themselves harmful but forcing the drug trade to move from one country to another may hurt the new producer country more than it helps the old one. Hence, the U.S. government should no longer push for "global containment", as the policy has been defined. Rather, it should focus attention and resources on supporting the few states both willing and able to do something about production or trafficking in their countries. Unfortunately, Afghanistan, the center of attention right now, is not one of those countries.

The United States has been the principal driver of international drug control efforts since 1909, when it convened a meeting of the International Opium Commission (primarily aimed at helping China cut its opium consumption). The U.S. pushed the creation of the web of prohibitionist international treaties under the auspices first of the League of Nations and then the United Nations. It is the dominant voice at the annual meetings of the Commission on Narcotic Drugs, the UN forum for discussing drugs. In that forum it has stood firm against any softening of existing policies. Most prominently, the United States has denounced in recent years "harm reduction" interventions such as needle-distribution programs aimed at reducing the spread of HIV. The Obama administration changed this policy at the 2009 Commission on Narcotic Drugs meeting in Vienna in March.

Though not a lot of money (by the standards of the U.S. drug budget) is spent on overseas drug control, Plan Colombia ($5 billion since 2001) is by far the largest U.S. foreign assistance program in Latin America, making Colombia the fourth largest recipient of U.S. aid.

What these policies and programs seem not to have done is to reduce either the American or the global drug problems. That is not the consequence of badly designed programs or administrative incompetence, though both are frequently found. Rather, it's a result of the fact that international programs like eradication or interdiction simply cannot make much of a

[24] This section is adapted from Reuter (2009) "Do no harm: sensible goals for international drug pollicy" The American Interest IV(4) 46-52

difference because they aim at the wrong part of the drug problem: production and trafficking in source countries. The right part of the problem to aim at is demand in importing countries, including our own. But, of course, that is difficult and uncertain task, and even successful programs take a long time to have much effect.

It would not be wise to close up shop altogether. After all, there are some connections between the illicit drug trade and terrorist financing which Americans would be foolish to ignore and there may occasionally be promising opportunities to help specific countries. But we should adopt more limited, common sense goals for U.S. international drug policy, and when other U.S. interests conflict with drug control objectives in source countries, we should be more willing to defer to those other interests. Since heroin and cocaine dominate global concerns, let's focus of those drugs, and not drugs like marijuana, which are primarily domestic.[25]

Cutting Drug Exports

The United States has pushed three types of programs to cut source country production: eradication, alternative development and in-country enforcement. Eradication, usually involving aerial spraying, aims literally to limit the quantity of the drug available in the United States, raise the costs of those drugs, or otherwise discourage farmers from producing them. Alternative development is the soft version of the same basic idea. It encourages farmers growing coca or poppies to switch to legitimate crops by increasing earnings from these other products—for example, by introducing new and more productive strains of traditional crops, better transportation to get the crops to market or some form of marketing scheme. Finally, the United States pushes other countries to pursue traffickers and refiners more vigorously. None of the three has worked all that well.

Few countries are willing to allow aerial eradication, which may cause environmental damage. It is also politically unattractive because it targets peasant farmers, who are among the poorest citizens even when growing coca or poppy. Colombia and Mexico, neither one traditional producers of drugs, have been the producer countries most willing to allow spraying. Most others allow only manual eradication, a slow and cumbersome method.

[25] This analysis draws heavily on Paoli, L., Greenfield, V. and P. Reuter (2009) The World Heroin Market: Can Supply be Cut? Oxford University Press

The fundamental problem of source-country interventions aimed at producers of coca and poppy is easily described. These programs have always had a peculiar glamour and occupy a large share of the headlines about drug policy. But the fact that the actual production costs of coca or opium account for a trivial share of the retail price of cocaine or heroin dooms source-country intervenes as ways of controlling the problem.

It costs approximately $300 to purchase enough coca leaves needed to produce a kilogram of cocaine, which retails for about $100,000 in the United States when sold in one-gram, two-thirds pure units for $70 per unit. The modest share of the agricultural costs associated with cocaine production is easily explained: Production involves cheap land and labor in poor countries, and it requires no expensive specialized inputs. (Even Bolivia, the smallest of the three producer countries, has more than 500,000 square miles of territory—much of it opaque to surveillance.) Assume that eradication efforts lead to a doubling of the price of coca leaf, so that cocaine refiners now must pay $600 for enough leaf to produce one kilogram of cocaine. Assuming the doubled cost is passed along, the change in retail price will still be negligible. Indeed, leaf prices have varied enormously over the past decade, while the retail price of cocaine has fallen almost throughout the same period. If retail prices do not rise, then total consumption in the United States will not decline as a consequence of eradication. In this scenario, there will be no reduction in total production—just more land torn up in more places to plant an environmentally damaging crop.

There is, of course, a less harsh option for policy in the source country: alternative development. Offer the farmers the opportunity to earn more money growing pineapples than coca, and they will move to the legal crop, the argument goes.

Quite aside from the time and money it takes to implement a successful market-alternative crop program, the argument, alas, is subject to the same economic illogic as that for eradication. It assumes that the price of coca leaf will not increase enough to tempt the peasants back to coca growing. But as long as the price of leaf is so small compared to the street price of cocaine in Chicago, refiners will offer a high enough price to get back the land and labor needed to meet the needs of the cocaine market. Indeed, the prospects for alternative development are even bleaker because development takes time, time that allows other source regions to come on line. There has never been a documented case in which alternative development in source countries has had a demonstrated effect on drug use in downstream consumer countries such as

the U.S. To be sure, peasants will be better off than before the alternative development, but only because they will make more money growing coca. Mexican peasants are substantially better off than those in Bolivia, but that has not kept them out of the drug production business. Indeed, the same can be said for some Appalachian farmers, who play a role in the marijuana trade in the United States.

Three Countries, Three Problems

For the United States the international drug problem is dominated by three countries: Afghanistan, Colombia and Mexico. Each presents a different problem, both to the United States and to the producing country. But all three show why the elimination/interdiction approach to source country supply doesn't work.

Afghanistan is a special case because it is an important source country, but not for the U.S. The international heroin market is currently hemispheric, not global. The vast majority of heroin consumed now in the U.S. comes from Western Hemispheric sources. The U.S. is interested in Afghan drug production only because the U.S. has taken an interest in drug issues throughout the world, even if they have minor effects on U.S. drug use, and because drug trafficking in Afghanistan is intimately intertwined with terrorism. Most drug traffickers around the world are best thought of as ideologically neutral businessmen. However, the much invoked specter of narco-terrorism really does apply in Afghanistan.

The United States is trying to create an effective democratic state in Afghanistan. Despite the presence of 60,000 NATO and U.S. troops, Afghanistan's output of opium has increased massively over the seven years since the Taliban fell.[26] That has provided important funding for both the Taliban and al-Qaeda and for warlords independent of the central government. It has also worsened the country's deep-seated corruption. As revealed in a surprising *New York Times* magazine article by the former coordinator of U.S. counter-narcotics efforts in Afghanistan[27], there was much conflict within the Bush Administration about pursuing aggressive counter-narcotics efforts. Insiders argued over whether these efforts were needed to establish a strong state or, on the contrary, whether they would threaten the very existence of the Karzai government.

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[26] Estimates of opium production in 2996 and 2007 showed extremely large increases from 2002-2005 levels. These are implausible. See Reuter, P. and F. Trautmann (2009) Assessing the Operations of the Global Illicit Drug Markets European Commission

[27] Thomas Schweich, "Is Afghanistan a Narco-State?" New York Times Magazine, July 27, 2008.

The drug hawks have usually won the rhetorical battles, but they have lost the programmatic wars. In October 2008, Defense Secretary Gates declared that the U.S. military will go after traffickers and warlords, but will not eradicate poppy fields. Given the relative invisibility of trafficking, this is effectively a truce. But better a truce than a "war" against poppies that cannot be won and would be counterproductive politically if it were won.

The recent announcement that U.S. troops will pursue opium growers if their activity is supporting the Taliban represents a major change in approach.[28] While not claiming great expertise about the ground realities, such as the availability of accurate intelligence on the relationship between a particular grower and the Taliban, we are skeptical that this can be effectively implemented. It is likely to be yet another in the string of announcements of tough policies that have led to minimal intervention. However, if the effect is to displace production and trafficking from parts of Afghanistan where it generates revenues for the Taliban and moves it to other places not controlled by opponents of the Afghanistan government, it may be a sensible move – one with no appreciable effect on drug-related outcomes in the U.S. but with collateral benefits for other U.S. interests.

Colombia, unlike Afghanistan, is a principal producer of drugs for the United States, most prominently cocaine but also heroin. The United States has tried to strengthen a Colombian government long beleaguered by guerilla conflict, and in this it has succeeded reasonably well.[29] To the extent that the primary goal of assistance has been to reduce the flow of Colombian-produced cocaine into the United States, the policy has largely failed. To the extent that the real objective is to help a friend that has been harmed by U.S. demand for drugs, there are grounds for greater optimism.

Mexico, occasionally described as a natural smuggling platform, has been the principal drug transshipment country into the United States for almost two decades. The bulk of America's imports of cocaine, heroin, marijuana and methamphetamine all come through Mexico. Mexico's domestic drug consumption, while growing, has traditionally been far below that of many other producer and transshipment countries.

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[28] Filkins, Dexter. "Poppies a Target in Fight Agianst Taliban." New York Times, April 29, 2009 http://www.nytimes.com/2009/04/29/world/asia/29afghan.html?_r=1

[29] For a balanced assessment see GAO Plan Colombia Drug Reduction Goals Were Not Fully Met, but Security Has Improved; U.S. Agencies(2008) s Need More Detailed Plans for Reducing Assistance[GAO-09-71]

In the past two years the level of violence associated with the U.S.-destined drug trade has skyrocketed. Over 5,000 people were killed in drug-related violence in 2008; that included systematic terror killings of innocent individuals, honest police and reporters. This has happened partly because of changes in the trade itself and partly as a consequence of government efforts to control the violence. The new U.S. program to help Mexico—$400 million for training police and military—may ostensibly be aimed at cutting down the flow of drugs to the United States, but such low levels of funding are not likely to achieve much. The money is more properly viewed as reparations: Mexico is suffering from the consequences of our continued appetite for illegal drugs, so the United States has an obligation to help ameliorate those problems regardless of whether it cuts U.S. drug imports.

Strategic Consequences of the Balloon Effect

There is almost universal skepticism that international efforts by rich countries can reduce global production of cocaine and heroin. But efforts to curb production in specific places have had some effect. We noted that targeting Bolivian and Peruvian smuggling into Colombia helped make Colombia the dominant producer of coca. The Chinese government since about 1998 has pushed the United States Army to successfully (and brutally) cut Burma's production of heroin.[30] Spraying in Mexico in the 1970s shifted opium production from a five-state region in the north to a much more dispersed set of states around the country.

Interdiction can also affect the routing of the trade. In the early 1980s then-Vice President George H.W. Bush led the South Florida Task Force that successfully reduced smuggling through the Caribbean. The traffic then shifted to Mexico but the effort did help several Caribbean governments. Similarly, more heroin may now be flowing through Pakistan because the Iranian government has intensified its border control.

In recent years this kind of interaction has been most conspicuous with respect to cocaine trafficking. The Netherlands Antilles is conveniently located for Colombian traffickers shipping to Europe, as there are many direct flights from Curaçao to Amsterdam's Schiphol airport, one of the busiest in Europe. In response to evidence of growing cocaine trafficking to Amsterdam, the Dutch government implemented a 100 percent search policy for airline passengers in Curaçao in

[30] Fuller, Thomas. "Notorious Golden Triangle Loses Sway in the Opium Trade." Transnational Institute. http://www.tni.org/detail_page.phtml?act_id=17315

March 2004.[31] Whereas cocaine seizures in the Netherlands Antilles had not exceeded 1.3 tons before 2003, in 2004 they reached nine tons, a remarkable figure for a jurisdiction with fewer than 200,000 inhabitants. (The United States seizes only about 150 tons per year.) Shipments through Schiphol airport have since fallen sharply.

As a consequence, new trafficking routes have probably opened up from South America to Europe via West Africa. For example, Guinea-Bissau is impoverished and small, it has no military or police capacity to deal with smugglers, and its government is easily corrupted. Smugglers have begun using landing strips there for large shipments. In 2007, there was one seizure of three quarters of a ton, and it is believed that an even larger quantity from that shipment made it out of the country.[32]

Ghana, a larger nation but one with fragile institutions, has also seen a sudden influx of cocaine traffickers. In 2005, flights from Accra accounted for more seized cocaine at London's Heathrow airport than flights from any other city. There are now regular reports of multi-kilo seizures of the drug either in Ghana itself or at airports receiving flights from Ghana.

Assuming that Ghana and Guinea-Bissau are serving as trafficking nations at least in part because of the effective crackdown on an existing route through Curaçao, is the world better off? Certainly the Netherlands has helped itself. One can hardly be critical of a country making a strong effort to minimize its involvement in the drug trade. However, one can reasonably ask whether, in making these decisions, the Netherlands should take into account the likely effects of their actions on other, more vulnerable countries.

Awkward Choices

International drug policy will not be high on the Obama Administration's list of priorities, given that the U.S. drug problem itself is gradually declining. It has indeed not been a major issue for the Bush Administration. Congress was fairly passive on the issue during the Bush Administration, but those members who have been vocal have all been drug hawks, passionately arguing that this nation has a moral obligation to fight one of the great scourges of modern times on a worldwide scale. The public is apparently indifferent, seeing the drug problem as one for which every measure (tough enforcement, prevention or more treatment slots)

[31] United Nations Office on Drugs and Crime and World Bank, Crime, Violence, and Development: Trends, Costs, and Policy Options in the Caribbean (2007).

[32] Kevin Sullivan, "Route of Evil: How a Tiny West African Nation Became a Key Smuggling Hub For Colombian Cocaine, and the Price It Is Paying", Washington Post, May 25, 2008.

is fairly hopeless. This, in turn, has not encouraged liberal members of Congress to take on the issue.

Drug policy is one of many areas of international policy in which the Obama Administration would benefit from adopting a more humble attitude. The arrogance with which United States delegations at the annual Commission on Narcotic Drugs lecture the rest of the world would be laughable if it weren't for the fact that many nations are still cowed by the sheer scale of U.S. efforts. There is no evidence that the United States knows how to help reduce the world's drug problems or the ease with which cocaine, heroin and methamphetamine are procured and trafficked. Moreover, the harm that some of our interventions cause is more apparent than their benefits. For example, spraying coca fields in Colombia clearly has adverse environmental consequences if only because it spreads production further, and it also probably sharpens conflict between the Colombian government and its citizens. Pressing the Karzai government to spray poppy fields increases tensions with our allies. Our attack on drug policy initiatives in other countries exacerbates the U.S. reputation for bullying and disinterestedness in true multilateral collaboration. A less aggressive and more collaborative approach will help the U.S. foreign policy in many respects.

Concluding Comments

This testimony only covers some of the major issues facing the incoming Director of ONDCP. On the demand side raising both the availability and quality of treatment for drug dependence is clearly a first order priority. Finding better ways of funding effective prevention programs so that less is spent on programs that are known to be ineffective is also important. These are long-term priorities.

In the shorter run, cutting unnecessary incarceration and ensuring that US efforts overseas are more sensibly focused are both well worth the Director's attention. Helping push federal policy in these areas would benefit not only the nation but also the standing of the Office of National Drug Control Policy.

Mr. CUMMINGS. Thank you very much.
Mr. Charles, good to see you again.

STATEMENT OF ROBERT B. CHARLES

Mr. CHARLES. Sir, it is always a pleasure to be in front of you.

My thoughts today are elementary. I have a few simple if strongly held views to share. I find myself, by the way, in strong agreement with most of what Dr. Christopher and Dr. Carnevale had to say. My views are neither Republican or Democrat. They are what I would like to think of as common sense. They emerge from two decades of work in demand and supply, advising Federal, State, and local law enforcement, as well as State and national prevention, education, treatment, and law enforcement groups. They are distilled from a range of experiences, spending time as a circuit clerk on the U.S. Court of Appeals, in jails, schoolhouses, treatment facilities, and places as diverse and regularly there as Colombia, Bolivia, Peru, Mexico on one hand, Thailand, Malaysia, Laos on the other. I have even had the good fortune on hunkering down in Baghdad and Kabul to talk about counternarcotics. And the sad task also of helping parents who have lost kids to drugs re-find their life's purpose.

Professionally my views, as you know, sir, better than most, are molded by 5 years up here on the Hill. During that time I ran the Bipartisan Drug Policy Working Group co-chaired by Congressmen Zeliff and Rangel, Speaker Hastert's Drug-Free America Task Force, the subcommittee that you were the ranking member for that elevated and vetted drug related demand and supply reduction legislation, including the 1997 Drug Czar Reauthorization Act.

Finally, between 2003 and 2005, I was Colin Powell's Assistant Secretary handling narcotics issues in 70 countries, which brings me here today as nothing more than a commentator.

My short thoughts are these five.

No. 1, to cast the Nation's counternarcotics efforts over the past two decades as a waste of time, as misguided, as a failure, is simply wrong. We have collectively succeeded in many ways. For periods of several years at a time during both Republican and Democratic administrations we have managed to change attitudes and behavior patterns. The data is all there.

We have managed during these high attention times to educate young Americans well, to pull more addicted Americans back from the abyss, to reduce emergency room admissions for various illegal drugs, to reduce certain categories of violent and property crime tied to drug use, and concretely return the rule of law and stability to formerly drug-ravaged countries, and we can detail those if you want.

No. 2, what we have not been able to do in any permanent way yet is to erase the recurring need for education, treatment, and deterrence born of keeping narcotics at the front and center as a law enforcement and national security issue, community, family and personal responsibility issue. We have not found a way yet to sustain national will and attention around a topic that few like to discuss, either in their own lives, the lives of their families, or even schools and communities, never mind the Nation.

We have yet to erase the reality and the enormous heartbreak of drug abuse and addiction, drug-related accidents, drug-related suicides, the tragedy of sudden death by drugged driving, which is quite common. Falling educational performance tied to drug dependence. Drug-related abuse of women and children. By the way, both the Clinton and Bush Justice Departments put 80 percent of overall abuse; that is to say, domestic abuse, at the feet of substance abuse. Much of it is poly drug use.

We haven't been able to get away from the drug-related violence in our towns, cities, and at the Southwest border. And, yes, drug-funded terror groups, which now number more than 25, increasingly encroach on U.S. interests around the world and do include Hezbollah, Hamas, the PKK, mutations of the KLA, the FARC, AUC, Taliban, HIG, IMU, and a growing number of terrorist cells in this hemisphere. We do not even need to utter the word "Afghanistan." Portions of some of these groups are amply financed by our own drug abuse right here in the United States.

So despite successes, we face a challenge as meaningful and compelling as any that the Nation has wrestled with in decades.

No. 3, America needs to focus on both sides of drug abuse and drug crime, adequately and sustainably supporting both the health and law enforcement sides of our personal, family, community, State and Federal anti-drug efforts. To minimize the role of either law enforcement, often dubbed the supply side, since the aim is to deter drug production and trafficking, or the health-related requirements, including prevention and treatment costs, the so-called demand side, would in my view be a sudden turn for the worse. Moreover, to minimize either deterrence and what it takes to deter drug-related crime or health and prevention would be reckless.

No. 4, drug legalization is a non-starter, period. I have two studies that I urge be put in the record, one of which is a robust economic study on that topic. One of my graduate degrees is in economics. The economics of drug abuse, written large and small, are against anything like legalization.

To gain new perspective, just ask Sweden or the non-addicted people in any country where drug availability has risen. More drugs means more addiction, higher health care costs, lower educational performance, more property and personal crimes committed on drugs, which are six times as likely as crimes committed to get drugs, more domestic abuse, and a degradation in a variety of related health indicators, from inhibitions against unprotected sex to shared drug needles.

What is more, the nature of addictive commodities and sliding price elasticity of demand for drugs means that any legislation widening availability and use will accelerate emotional and physical damage to the very youth we hope in so many other ways to protect. To that, add the persistence of a drug black market, both empirically and because addiction means there will always be a black market until the day when drugs like heroin are given away 100 percent pure in any quantity that somebody wants.

In short, the case is a slam dunk against drug decriminalization or legalization or harm reduction, and the irresponsibility of discussing it as a real option is tantamount to discussing some other way in which we might legally conspire to victimize and deceive

our Nation's young people so as to pay our way, which actually it would not, out of State or Federal debt. No, there is no saving grace to promoting drug abuse. Full stop.

Five. Hope springs eternal for ways to save and protect young lives, to improve everything from education to deterrence. This Congress and this drug czar and President have a chance, a real chance, to show real leadership in the drug war, which has been lacking. Whether you prefer to talk about anti-violence and pro-law enforcement end of the spectrum or the pro-health care end of the spectrum, the spectrum, like any criminal issue with health consequences, from rape and maiming to assault and intentional infliction of emotional distress, is a continuous, unbroken, integrally related circle. Trying to fix the health consequences residing on one side of the circle without deterring the behavior and the means that create the opportunity and promote the opportunity and promote the other side, the ill health consequences on the other side, is to miss the point.

Mr. CUMMINGS. Mr. Charles, can you wrap up?

Mr. CHARLES. I will.

We must minimize the level of inattention that has been given to this, maximize the attention, and remember that in a nonpartisan way, quite frankly, we are due for some real leadership on this issue.

[The prepared statement of Mr. Charles follows:]

Testimony

Of

Robert B. Charles

Former Assistant Secretary of State, INL, for Colin Powell

Returning to Common Sense, Leadership and Bipartisan Effort

Against Narcotics Abuse, Crime and Addiction

Domestic Policy Subcommittee

Oversight and Government Reform Committee

Tuesday, May 19, 2009

2154 Rayburn HOB

2:00 p.m.

My thoughts are elementary today. I have a few simple, if strongly held views to share. These views cross party lines; there is nothing inherently Republican or Democrat about them. They are what I would dare to call common sense, the sorts of understandings that are nurtured in America's heartland and sustained by experience across the world.

These views emerge from a lifetime of work in both the demand and supply fields, not least advising or assisting federal, state and local officials, working with state and national prevention, education, treatment and law enforcement professionals and non-profits.

These views are distilled from studying both economics and law as a graduate student, and then serving in the larger counter-narcotics efforts for over 20 years in courtrooms, jails, school houses, treatment facilities, places as diverse as Colombia, Bolivia, Peru, Mexico on one hand, Thailand, Malaysia and Laos on the other. I have had the good fortune of hunkering down in Baghdad and Kabul to talk counter-narcotics, and the sad task of helping parents who have lost kids to drugs re-find life's purpose.

Professionally, my views are molded by five years up here, on the Hill, running a Bipartisan Drug Policy Working Group co-chaired by former Congressman Bill Zeliff and Charlie Rangel, Speaker Hastert's Drug Free America Task Force, and a subcommittee that elevated and vetted drug-related demand and supply-side legislation. I was a principle author of half a dozen pieces of legislation that helped, I would like to think, save young lives - from the 1997 Drug Czar Reauthorization Act to the Drug Free

Communities Act, from the Meth Trafficking Act to the Western Hemisphere Drug Elimination Act.

In the late 1990s I started teaching on counter-narcotics and oversight at Harvard's Extension School, in part because I felt no one was teaching much in those vital areas, and almost no one was teaching about the area in which those two subjects -- drug policy and oversight -- overlapped. In 2003, I wrote the book Narcotics and Terrorism because the links were too bold to ignore, and from late 2003 to 2005, I was permitted the great honor of being Colin Powell's Assistant Secretary of State for both counter-narcotics and law enforcement ... handling both demand and supply anti-drug programs in 70 countries.

... Which all brings me here today, at a time when I am again no more than a commentator. My thoughts in short are these:

(1) To cast the nation's counter-narcotics efforts over the past two decades as a waste of time, as misguided, as a failure is simply wrong. We have collectively succeeded in many ways. For periods of several years at a time, during both Republican and Democratic administrations, we have managed to change attitudes and behavior patterns. We have managed during the high-attention times to educate young Americans well, pull more addicted Americans back from the abyss, reduce emergency room admissions for various illegal drugs, reduce certain categories of violent and property crime tied to drug use, and concretely return rule of law and stability to formerly drug-ravaged countries.

(2) What we have not been able to do in any permanent way yet is to erase the recurring need for education, treatment and the deterrence born of keeping narcotics at the front and center as a law enforcement and national security issue, community, family and personal responsibility issue. We have not found a way to sustain national will and attention around a topic few like to discuss, either in their own lives, the lives of their families or even their schools and communities, never mind the nation. We have yet to erase the reality and enormous heartbreak of drug abuse and addiction, drug-related accidents, drug-related suicides, the tragedy of sudden death by drugged driving, falling educational performance tied to drug dependence, drug-related abuse of women and children (80 percent of which is tied to substance abuse according to both the Clinton and Bush Justice Departments) , drug-related violence in our towns, cities and at the SW border, and - yes - drug-funded terror groups which now number more than 25, increasingly encroach on US interests around the world, and include Hezbollah, Hamas, the PKK, mutations of the KLA, the FARC, AUC, Taliban, HIG, IMU, and a growing number of terrorist cells in this hemisphere and across the globe. We do not even need to utter the word Afghanistan - portions of some of these groups are amply financed by our own drug abuse right here in the US.

So, despite successes, we face a challenge as meaningful and compelling as any the nation has wrestled with in decades. We have not found a cure for cancer, and have not convinced all Americans to stop committing any number of felonies, but we continue to try. We continue to try here, and must do so with open eyes, open hearts and vigilance. ***We can improve. But we should not forget that the battle for hearts and minds that decidedly reject drug abuse and drug-related crime at home, here in America, has been joined and to good effect. That same battle, on multiple fronts has been joined to good effect abroad. We must not give up past methods or gains in the process of finding better ways to engage and protect people.***

(3) America needs to focus on both sides of the drug abuse and drug crime phenomenon -- adequately and sustainably supporting both the health and law

enforcement sides of our personal, family, community, state and federal anti-drug effort. To minimize the role of either law enforcement- often dubbed the supply side, since the aim is to deter drug production and trafficking -- or the health-related requirements including prevention and treatment costs, the so-called demand side -- would in my view by a sudden turn for the worse. Moreover, to minimize either deterrence and what it takes to deter drug-related crime or health and prevention, would be reckless.

(4) Drug legalization is a non-starter, period. The economics of drug abuse - written large and small - are against anything like legalization. To gain new perspective, just ask Sweden or the non-addicted people in any country where drug availability has risen. More drugs means more addiction, higher health care costs, lower educational performance, more property and personal crimes committed on drugs -- which are six times as likely as crimes committed to get drugs, more domestic abuse, and a degradation in a variety of related health indicators, from inhibitions against unprotected sex to shared drug needles. What is more, the nature of addictive commodities and sliding price elasticity of demand for drugs, means that any legislation widening availability and use, will accelerate emotional and physical damage to the very youth we hope in so many other ways to protect. To that, add the persistence of a drug black market, both empirically and because addiction means there will always be a black market until the day when drugs like heroin are given away at 100 percent purity in unlimited quantity. In short, the case is a slam dunk against drug decriminalization or legalization or harm reduction - and the irresponsibility of discussing it as a real option is tantamount to discussing some other way in which we might legally conspire to victimize and deceive our nation's young people so as to pay our way -- which would not happen either -- out of state or federal debt. No, there are no saving graces to promoting drug abuse. Full stop.

(5) Hope springs eternal for ways to save and protect young lives, improve everything from education to deterrence. This Congress and this Drug Czar and president have a chance to show real leadership in the drug war, whether you prefer to talk about the anti-violence and pro-law enforcement end of the policy spectrum or the pro-health care end ... The spectrum, like any criminal issue with health consequences, from rape and maiming to assault and intentional infliction of emotional distress, is a continuous, unbroken, integrally-related circle. Trying to fix the health consequences residing on one side of the circle without deterring the behavior and means that create the opportunity and promote the ill-health consequences is to miss the point. Both sides of this battle need our attention - we must minimize supply and access, deter trafficking and distribution, while educating and treating the wounded. Sadly, this is not simply a drug war or a drug epidemic - it is both a drug war on those organized to victimize with weapons and narcotics as their means, and it is an epidemic for those caught in the web of use, dependence and addiction. We must stop creating straw men for the satisfaction of speaking a different truth, and recognize that both sides are telling the truth - drug abuse and drug-related violence are one enemy, and they need an

integrated, earnest, non-political response from those in a position to save that young life - any young life - that will otherwise be needlessly be lost to crime or addiction.

That, ladies and gentlemen, is all from me just now. Thank you.

Mr. CUMMINGS. I want to thank all of you for your testimony.

Dr. Christopher, tell me, in its report NAPA cited a lack of expertise in the work force at ONDCP saying that they needed more to be able to accomplish their mission. What types of skill sets and expertise are needed most to make the organization effective and efficient?

Ms. CHRISTOPHER. Thank you for the question. Since the first priority for ONDCP is to understand the scope and nature of the drug problem, it first must have competent statisticians who are equipped to utilize the wealth of survey data that is available to gain a better understanding of the many facets of the drug problem, and certainly the idea of a new deputy that brings a medical and preventive background speaks to the skill deficit in a very effective and creative way.

The office also requires competent economists who are able to conduct in-depth analysis of the global drug market. Understanding markets generally is one thing, but understanding a complex global illicit market with limited market indicators is another more difficult assignment.

Much data is collected about the illicit drug market demand, but less is known about market supply. This is an area where ONDCP can truly provide value-added as a coordinator of the National Drug Control Program.

The academy report also focused in on the need for more diversity of the agency's staff, given the disproportionate impact of these issues in diverse minority communities.

Mr. CUMMINGS. Dr. Carnevale, one of the things that I am concerned about is the whole drug court situation. I think drug courts are very effective. It seems to me the President's budget calls for $59 million of new problem-solving—it says "problem-solving court initiatives." Apparently what that means is there are discretionary funds, and then drug courts have to compete for those funds. Are you familiar with that? Are any of you familiar with that?

Mr. CARNEVALE. I am familiar with the program, yes.

Ms. CHRISTOPHER. Yes.

Mr. CUMMINGS. That concerns me. I think drug courts, as I said before, have been very effective. They put a carrot and stick approach. In Baltimore we have found them to probably—this is basically talking to judges, and judges have no reason to exaggerate. But they claim that it is one of the best tools that they have. I am just wondering what you all's opinion of, you know, putting money out there so that these drug courts that already are scraping for money, trying to find money wherever they can.

As a matter of fact, one of our drugs courts in Baltimore basically has had to go to some private foundations and whatever trying to put together the pieces for something that has been very effective. I am just wondering what you all's opinion on that might be?

Mr. CHARLES. Let me say, Mr. Congressman, I am 100 percent for it. I will just tell you, as you know probably as well as anyone, over the last 8 years the Byrne/JAG grant money was dramatically cut from its high of $1.3 billion at the end of the Clinton years, and it is a travesty that we have lost that emphasis. Some of the money actually goes to that purpose, just as it is vital to restore the Safe and Drug-Free Schools money.

Mr. REUTER. If I could just add, one of the problems with the drug courts is that the eligibility criteria for defendants are so strict that in fact it doesn't make a large difference in the great body of criminal justice decisionmaking. In fact, if you are an experienced heroin addict, you almost certainly are not eligible for a drug court, simply because you will have accumulated a criminal history that doesn't allow you in there. The advances in drug courts will come from changing the eligibility criteria, which is not actually I think on the agenda.

Mr. CUMMINGS. Well, I can tell you, in Baltimore they would disagree with you, Mr. Reuter, because, again, I trust my judges, and they have begged for drug court money. They said they would almost rather have drug court money than almost anything else, because they see that it works.

You have an opinion on that, Dr. Christopher?

Mr. CHRISTOPHER. I do. The drug court process, we at the Kellogg Foundation, which is another hat that I wear, are actually funding drug courts in Michigan because we find them to be extremely effective, particularly when you talk about the impact on child welfare and family dissolution. So many of the cases that come into the system where children are being removed has, of course, to do with various forms of substance abuse. So being able to use this type of approach has proven to be extremely effective.

Mr. CARNEVALE. Mr. Cummings, if I may comment on that as well, the drug court program I think has been very effective in targeting a certain population and needs to be expanded. It hasn't really seen much growth in the past 8 years. And I think we are all pleased to see the budget request that came in.

One element of the drug court program that I think is very important that is often overlooked is the Drug Court Institute that is currently in place. It is only funded I think at around $1 million, but it puts information on best practices that is disseminated to all drug courts nationwide. And as we expand the number of drug courts, I think it is also very important that Congress help this institute grow with it so it can help all these drug courts be more effective and get a little bit more mileage for the money that they are getting.

Mr. KUCINICH [presiding]. I thank the gentleman.

The Chair recognizes Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman. If I could first of all ask unanimous consent that two attachments be included. One is a Harvard Journal, a legislative article entitled, "Back to the Future: The Collapse of National Drug Control Policy. A Blueprint for Revitalizing the Nation's Narcotics Efforts." And the other is a second study done by Mr. Charles entitled, "Economic Thinking on Addiction and Legalization."

[The information referred to follows:]

New Economic Thinking on Addiction and Legalization

Toward Sliding Price Elasticities of Demand for Addictive Substances and their Implications for Public Policy

By Robert B. Charles

Commissioned by:
The National Alliance for Model State Drug Laws
National Alliance for Model State Drug Laws
July 2003

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The research conducted for and referenced in ***New Economic Thinking on Addiction and Legalization*** is current through December 2002.

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About the National Alliance for Model State Drug Laws

The National Alliance for Model State Drug Laws (the Alliance) is a resource for governors, state legislators, attorneys general, drug and alcohol professionals, community leaders, the recovering community, and others striving for comprehensive and effective state drug and alcohol laws, policies, and programs. The Alliance is the successor of the President's Commission on Model State Drug Laws. Funded by Congressional appropriations since fiscal year 1995, the Alliance is a 501(c)(3) nonprofit organization.

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Forward from the National Alliance for Model State Drug Laws

The idea of commissioning ***New Economic Thinking on Addiction and Legalization*** came through the Alliance's work with people at the state and local levels to address alcohol and other drug problems. As elected officials, state agency staff, addiction treatment professionals, law enforcement officials, community members, and others worked to implement our model laws and related policy elements, they were frequently challenged to consider the option to legalize marijuana and/or other illegal drugs. They came to the Alliance for information that would help them to better understand legalization and its potential consequences for their states and communities.

In reviewing the current literature and accounts of legalization, we found that the majority of the materials appeared to be political, moral, philosophical, and/or emotional in their presentation of the related issues. While there were some references to supply and demand arguments, there seemed to be a scarcity of objective discussion of the complex economic dynamics related to the use of, abuse of, and addiction to alcohol and other drugs and the possible impact of legalizing an array of potentially addictive substances.

As this document goes to print, states are confronting one of their most difficult financial times in recent history. Decision makers are challenged to use limited - in many cases, diminishing - resources in the most efficient and effective ways possible. Therefore, efforts to address alcohol and other drug problems must speak both to the issues faced and to the fiscal "bottom line." On behalf of the Alliance, I hope that ***New Economic Thinking on Addiction and Legalization*** will provide useful information and fresh perspectives to everyone considering these important issues.

Sherry L. Green, Esq.
Executive Director
National Alliance for Model State Drug Laws
July 2003

About the Author

Robert B. Charles

Robert B. Charles is president of The Charles Group, a public policy consulting firm based in Gaithersburg, Maryland. A former litigator in New York and Washington, Mr. Charles worked at Weil Gotshal & Manges and Kramer Levin between 1988 and 1995. He also clerked on the U.S. Court of Appeals for the Ninth Circuit.

During the Reagan and first Bush White Houses, Mr. Charles held policy positions in these administrations. He was appointed Deputy Associate Director of the White House Office of Policy Development, where he served from 1992-1993. From 1995 to 1999, he was Chief of Staff and Chief Counsel to the United States Subcommittee on National Security, International Affairs, and Criminal Justice. He also served as chief staffer to the United States Speaker of the House Task Force on Counternarcotics. In these roles, Mr. Charles crafted major provisions of key bills, negotiated elements of omnibus appropriations bills on behalf of House Leadership with the White House Office of Management and Budget, and held hundreds of hearings, mark-ups and investigations from 1995 forward. Hearings and legislation ranged from the Department of Defense oversight and law enforcement issues to the Drug War and health care; from the Department of Justice and Waco hearings to NASA and State Department oversight; from the United States Coast Guard and Customs oversight to review of DEA, FBI and INS practices and budgets.

From 1998-2001, Mr. Charles taught both Government and Cyberlaw at Harvard University Extension School. In 2000, he was awarded the Petra T. Shattuck Award for Excellence in Teaching by Harvard University.

A native of Maine, Mr. Charles graduated magna cum laude from Dartmouth College with a Bachelor of Arts in government. He also holds a Master of Arts in politics, philosophy and economics from Oxford University (P. P. E., 1984) and a law degree from Columbia University School of Law (J. D., 1987). As a regular writer and commentator in print and broadcast media, Mr. Charles remains close to many top decision makers in Washington. He lives in Maryland with his wife and two children.

Abstract

This economic study explores the idea that a sliding Price Elasticity of Demand (PED) may exist for any addictive substance; that this PED consistently slides from high to low over the cycle of addiction; that different addictive substances have different sliding PEDs; and that the existence of different sliding PEDs for addictive substances carries public policy implications. Specifically, the findings in this study suggest that, in practical and economic terms, the concept of a sliding Price Elasticity of Demand for addictive substances is important.

Policymakers can best reduce the costs associated with drug use and addiction in two ways:

- First, they can aggressively deter first time purchasers through policies that raise market prices and educate potential consumers just prior to market entry, taking advantage of the high Price Elasticity of Demand at that time.

- Second, policymakers can aggressively intervene to permanently end addiction through treatment regimes dedicated to stopping (not substituting) consumption of addictive substances, restoring rational economic decision making to consumers affected by addiction, and maintaining this rational economic behavior over time, in response to consistently low Price Elasticity of Demand for different drugs among addicted consumers.

Executive Summary

Any consumer of an addictive substance begins with a first use of that substance. That decision is informed by the costs of use, including price, risk of addiction and other adverse health effects, and perceived benefits of use. As the consumer migrates from treating the addictive substance (for example, cocaine or alcohol) as a "luxury" to treating that same substance as a "necessity," substantial research indicates that the Price Elasticity of Demand (PED) for the drug shrinks – that is, the degree to which use is affected by price falls. Unlike the first time purchaser of drugs, who is assumed to have weighed the addicted substance's putative effects against costs and risks, often based on information (accurate and inaccurate) collected from peers, media, parents and the community-at-large, an addicted person's decision-making is defined by the state of addiction.

Predictable operation of the laws of supply and demand, requiring rational consumer behavior, seems not to work when applied to the addicted consumer. Price becomes less important to the addicted consumer. Consistent with the clinically proven elements of addiction, including dependence and tolerance, the market as applied to this consumer is no longer characterized by free and rational choice. The Price Elasticity of Demand has fallen to a low point. In other words, large changes in price do not affect the addicted person's demand for the addictive substance or commodity, even if they do affect first time or non-addicted purchaser choices.[1]

To be sure, there is a considerable body of writing that discusses the non-economic arguments for and against different methods of treating addiction, as well as a considerable body of opinion containing non-economic arguments for and against policies raising or lowering the price of various addictive substances, ranging from legalization of illegal substances to taxation of legal and addictive substances. There is also a body of writing propounding narrow-gauge analysis of economic factors which might come into play if different policy options were pursued, and another body of writing best described as pseudo-economic, in that these authors tend to reason from broad and unsubstantiated assertions to broad and unsubstantiated conclusions.

This study does not take any of these tacts. It explicitly does not address any of the (possibly quite valid) political, social, philosophical, moral or emotional arguments surrounding different types of drug use or addiction policy. It also does not pursue a narrow-gauge economic approach, isolating one variable and ignoring others in an effort to make pure the economic analysis. A number of variables are discussed, while the importance of recognizing sliding PEDs for different drugs and purchaser groups is viewed as central to future public policy. Finally, the pseudo-economic writers are addressed directly in several instances, without disparaging the merit that may attach to ideas raised.

Primary Findings

After reviewing, analyzing and discussing the relevant economic and medical literature, this study's primary findings are as follows:

- Policies that lower the price of addictive substances tend to increase first time use or initiation rates for these substances.
- Increased use or initiation rates tend to increase addiction rates, based on responsiveness of first time and casual purchasers to lower prices.
- Raising prices of an addictive substance generally appears to lower the rate of first time use or initiation for most addictive substances, although higher prices do not appear to have any substantial impact on consumption by the addicted population.
- Substitution of one addictive substance for another similar substance by the addicted population appears more likely at higher prices and in the event of lower availability.
- Substitution may include accessible, affordable treatment to end the addiction where available, but is less likely to occur where significant effort is required by an addicted population to obtain the treatment.
- Rational or free choice by the addicted population appears to be significantly impaired by a combination of the cognitive deficit produced by using certain addictive substances (i.e. cognitive changes in brain function created by use of the addictive substance) and what is generally described as compulsion, a combination of dependence and growing tolerance to the addictive substance.
- Addictive substances appear to be comparable to one another on several bases, including abusive potency, addictiveness based on time to dependence and rate of tolerance growth, severity of withdrawal symptoms, adverse collateral health, adverse brain function effects and overall physiological and psychological change induced by the addictive substance.
- A price versus time-used continuum appears to exist on which most addictive substances can be placed somewhere relative to one another.
- This price versus time-used continuum reflects the price sensitivity of purchasers at different times in the use cycle (from first use to addiction) for any given addictive substance relative to any other addictive substance, even if the absolute sensitivity to price by purchasers at a particular time for a particular addictive substance is elusive.

- *Most discussants of legalization or government distribution of addictive substances do not take account of predictable long-term growth in the population of addicted persons and/or the long-term addiction costs associated with this policy choice.*

- No discussant of legalization or government distribution of addictive substances takes account of the vast literature supporting a Price Elasticity of Demand for addictive substances that consistently slides from high PED to low PED, albeit at different rates for different addictive substances, unless the addicted population becomes unable to act upon the low PED or substitutes treatment for addiction.

- No discussant of legalization or government distribution of additive substances takes account of the implications associated with a Price Elasticity of Demand that consistently slides, at varying rates for different addictive substances, from high to low for all measured addictive substances, unless the addicted population becomes unable to act upon the low PED or substitutes treatment for addiction.

- Much of the literature on economics and addiction, as well as economics and drug abuse, focuses on a single variable to the exclusion of other variables materially affecting conclusions drawn (i.e. assuming away difficult questions) or is unsubstantiated or opinionated in nature.

- Insufficient economic data and insufficient stratification of purchaser groups exists to confidently measure or estimate the absolute prices (or price ranges) at which different purchaser cohorts (e.g. first time, occasional, frequent and addicted purchasers)[2] will choose to purchase or not to purchase different addictive substances.

- Insufficient economic research has been done on the efficacy of generally applying traditional supply and demand principles to the use of addictive substances by different purchaser cohorts (e.g. first time purchase, occasional, frequent and addicted purchasers).

Key Conclusions

This study yields two basic, but important, conclusions:

First, the existence of a high Price Elasticity of Demand for addictive substances at the time when consumers evaluate whether to initiate use of an addictive substance, paired with the high potential costs of addiction to both the individual and society, strongly reinforce policies that have: 1) the effect of creating and maintaining high prices in order to deter first use, and 2) the effect of educating potential first time purchasers about the risk of, and costs associated with, possible addiction.

Since the ability to influence consumer decision making is at an apex just prior to the consumer's decision to purchase, or when the potential first time purchaser is deciding whether or not to enter the market, policies targeting price and education at this time – even marginally – are most likely to reduce use and addiction. On the other hand, policies seeking to significantly deter consumption among *people with addictions* through changes in price are not likely to be cost-effective.

Second, the existence of consistently low Price Elasticity of Demand among addicted consumers or frequent purchasers of addictive substances, paired with the adverse economic effects of this consumer group's behavior on individual consumers and society at large, strongly reinforce policies that have: 1) the effect of restoring rational consumer decision making, 2) the effect of reducing consumer dependence on and tolerance for these addictive substances, and 3) the effect of restoring this group of consumers to a position of involvement in the economic system based on predictable interplay of supply and demand, namely a position maintained prior to first use of the addictive substance.

While there are points after first use and prior to addiction in which price and education may influence consumer behavior, and there are cognitive elements of the decision-making process which may never be restored even after intervention, the most cost-effective way for any society to reduce the cost of addiction is to intervene with effective treatment for one purpose: to end consumption of the addictive substance.

A consumer caught in the economic trap of addiction to a substance with a low Price Elasticity of Demand is not freed by replacing one addictive substance with another. While this policy might be able to reduce the adverse effects of the first addictive substance and replace them with the adverse effects of the second addictive substance, such substitution does not reduce either the costs or the opportunity costs associated with addiction. Moreover, policies that seek to substitute one addiction for another in the name of cost savings tend to be highly expensive and offer no measurable cost-benefit over time, other than accelerating the progress of adverse health effects and death, which reduces the cost to society of health care and addiction maintenance for that consumer.

Substitution of addiction-ending treatment for addiction is only cost-effective when sustained over time; thus, policies that actively intervene to end addiction must be coupled with policies which educate the formerly addicted consumer to maintain his or her economic position. While price may then play a modest role in governing the consumer's behavior, other factors beyond price are likely to be equally important, as the consumer may never be as sensitive to price as he or she was prior to first use.

Core Recommendation

The study's core recommendation is simply put:

In practical and economic terms, the concept of a sliding Price Elasticity of Demand for addictive substances is important. Policymakers can best reduce the costs associated with drug use and addiction in two ways:

- First, by aggressively deterring first time purchases through policies that raise prices and educate potential consumers just prior to market entry, taking advantage of the high Price Elasticity of Demand at that time

- Second, by aggressively intervening to permanently end addiction through treatment regimes dedicated to stopping (not substituting) consumption of addictive substances, restoring rational economic decision making to consumers affected by addiction, and maintaining this rational economic behavior over time in response to consistently low Price Elasticity of Demand for different drugs among addicted consumers.

Introduction and Overview: Rolling Out a New Idea

The purpose of this study is several-fold. It provides an overview of economic research on a critical slice of public policy, namely whether, how, to what degree and when the price of an addictive substance affects consumption.

Stepping beyond current research, a new - and potentially explosive - argument is presented. The argument deserves more research and discussion: while higher prices may negatively affect initiation rates for *new* consumers of drugs and alcohol and lower prices may naturally increase the likelihood of wider *initiation* of use, the supply and demand model breaks down when discussing *prolonged* use of addictive substances.

Simply put, price becomes less important for purchasers as they become more addicted. The new element contained in this assertion is that there are more than one or two points at which Price Elasticity of Demand (PED)[3] can be measured and matter. Rather than assuming a static PED for certain drugs used by first time and addicted purchasers, this study explores the possibility that Price Elasticity of Demand for any addictive substance is dynamic, changing continuously over time, and is different from drug to drug.[4]

As a given purchaser migrates from treating a drug (e.g. cocaine, alcohol) as a "luxury" to treating that same drug as a "necessity," price elasticity of the drug shrinks – that is, the degree to which use is affected by price falls. Unlike the first time purchaser, who is assumed to have weighed a drug's putative effects against perceived risks and costs, often based on information (accurate and inaccurate) collected from peers, media, parents and the community-at-large, an addicted person is typically caught in the cycle of addiction. This individual is often not in a frame of mind to weigh choices rationally.[5]

Ironically, both current "rational addict" research and application of the supply and demand model presume a degree of free will in the decision-making process.[6] To the extent that they address the issue at all, they assume that the price elasticity of a particular drug will – for any given purchaser, whether first time, occasional or prolonged – be constant.

The kernel of this study, which should trigger further research for those who grasp the argument's significance, is a careful presentation of data suggesting that this core assumption may be wrong.

If the prevailing assumption – that the PED remains constant – is wrong, then increased availability of any drug will increase use,[7] which predictably increases the cohort of those becoming addicted, and the measurable health costs associated directly and indirectly with addiction.[8] This is a sobering connection of previously ac-

cepted and well-documented economic and statistical "dots," creating a picture that mitigates both *against* the widening availability of drugs through legalization or any other means, and *in favor* of more proactive efforts to retrieve a society's addicted population from what is an economic trap.

In economic terms, *this study argues that Price Elasticity of Demand* (that is, how demand "bounces" or changes in response to changes in price) *does not remain constant for an addictive substance*, even though *price and quantity are typically constant for most non-narcotic and non-addictive substances*. Why this matters will become more apparent in this study.

Before exploring the implications of this largely unexplored idea, a *corollary* is also worth mentioning. Just as ordinary market assumptions about purchasing behavior may not apply to addictive substances, particularly at the highly addictive end of a yet-to-be-established *addiction spectrum*, there is every reason to believe that *the more addictive a narcotic, the less price will matter to those who are addicted.*

The nature of addiction is both central to – and beyond the scope of – this paper. That said, the notion that addictions come in various types, affected both by the type of addictive substance being consumed and the person consuming, is commonly accepted. For example, while heroin, methamphetamine, Ecstasy and PCP ingestion, at the currently high purity levels, will often lead to a high proportion of first time emergency room incidents and deaths,[9] other addictive substances take a longer period to produce death and organic damage.[10] Based on the type of drug, consumer disposition and environment, addiction may occur rapidly or more gradually. One factor in assessing the likely rate of addiction is the drug being consumed. Thus, for opiates, addiction may be swift,[11] while for alcohol it may be more gradual.[12]

As with any product, there may be *substitution* of one addiction for another if wide price differentials exist and the drug-induced effects are viewed as similar (e.g. swapping methamphetamine addiction for cocaine addiction, or OxyContin addiction for heroin addiction), but *the corollary is not altered by substitution.*[13]

Addiction to a non-narcotic is, by definition, less likely than addiction to a narcotic. Addiction to a *highly* addictive narcotic is, by definition, more difficult to break than addiction to a *less* addictive narcotic. Thus, the Price Elasticity of Demand for milk may be constant over time, while the price elasticity for alcohol or cigarettes may be expected to slide less rapidly than for heroin from high to low.[14]

This corollary, like the rule before it, has a common sense kicker: Price Elasticity of Demand (how much a change in price affects consumption) may not only slide, but slide at different speeds, based on the drug to which the Price Elasticity of Demand is attached. The slide is likely to be steeper for highly addictive substances than for less highly addictive substances.[15]

In short, the speed at which certain Price Elasticities of Demand slide from high to low may be *measurably* different. One may be able, for example, to organize in ascending or descending order a variety of addictive drugs based on the speed with which they induce addiction. With this comes the corollary that some drugs can be described as having "swiftly sliding" Price Elasticities of Demand (from high to low), while other drugs trigger a "slowly sliding" Price Elasticity of Demand. Cocaine, heroin, Ecstasy, methamphetamine, OxyContin and marijuana might fit into the first category while nicotine, alcohol, weak prescription medications or over-the-counter drugs might fit into the latter.[16]

In everyday terms, which economists often eschew, both ideas can be simply illustrated. The first rule that drugs of any type slide down the so-called price elasticity scale - starting as a luxury and ending up a necessity – is illustrated best by analogy. Marijuana, cocaine and heroin are highly addictive substances, while baseball games, carnival rides and cotton candy are not. If prices rise on baseball tickets, carnival rides or cotton candy – especially if the price rise is substantial – buyers pass on the opportunity to buy (i.e. decide not to buy). Similarly, if prices are high for drugs, first time purchasers act the same way as a non-addicted buyer would act for any non-addictive commodity, such as baseball, carnival tickets, or cotton candy: they do not buy.

On the other hand, if drug prices rise for the addicted person, freedom to avoid buying is limited, if viewed as existing at all. Physiological and psychological dependencies dictate that higher prices will be met. Both addictive science and criminal justice data support this conclusion. Accordingly, drug addicted persons do not choose *not* to buy drugs as prices rise, since that is not typically viewed as an option.

While lower prices appear to spur buying of drugs by non-addicted persons[17] and higher prices appear to reduce first time buying by non-addicts,[18] there is evidence that higher prices may not reduce the buying of drugs by addicted persons. The wider policy implications of this argument are explored in this study.

In the same vein, again by example, if tetrahydrocannabinol (THC)[19] levels in modern marijuana are more addictive than less addictive substances (e.g. caffeine, nicotine)[20] and cocaine is more immediately addictive than THC,[21] it may be possible to establish a schematic charting the progression of addiction, associating certain outcomes with particular drugs or the "abusive potency" of these drugs.[22] There is even a chance that consensus could be created around the levels or degrees of addiction that follow particular drugs, such that greater and lesser initial price elasticities could be attached to each drug (paired with the speed or steepness at which a purchaser slides toward addictive dependence after a first use).

In the end, all drugs end up near zero price elasticity, since this is the economic definition of a seemingly inescapable addiction. That said, some drugs (e.g. heroin) clearly force a user toward addiction on a compressed timetable. The user is forced

toward the "necessity" end of the price elasticity scale faster than the user of a less addictive substance (e.g. tobacco).[23]

Among non-addictive substances, there is little to illustrate the effect of more and less addictive behaviors since there is a common assumption: it is assumed that price elasticities for a non-addictive substance not only stay unchanged when all else is held constant, but also that price elasticities for non-addictive substances seldom end up at zero. The substitution effect is constantly in play in the market for non-addictive substances. There is a common assumption that even such necessities as toilet paper or food staples would be replaced by other non-addictive commodities if prices on desired commodities soared. In short, no matter how much a consumer likes bananas or eggs, a consumer would turn to apples or other sources of nutrients if the first choice items became too expensive.

While there is a raft of literature suggesting outcomes that associate or correlate with particular drugs, *one project not evident in the literature is defining a universe of behavioral types which attach more quickly or more severely to particular drug types and putting the various drugs abused into some ordinal chart or order.* A scouring of the literature, and review by treatment and medical experts, would then allow these addictive behaviors and drugs *to be assigned particular price elasticities, each of which shifts from high (e.g. at first time use) to low (e.g. after psychological or physical addiction begins). Given differing drug effects, the assigned price elasticities would also likely shift at different speeds.*

Why does all this matter? Who cares whether drugs actually have – and are recognized to have – sliding price elasticities, and whether they differ from one another in important ways? If the two principles spelled out above are true, *there are major policy implications.*

These implications are not related to or compelled by state or federal politics, public morality, perceived criminal justice imperatives, treatment preferences, or the viability of competing or complementary prevention modalities. *They are purely economic.*

The conclusion toward which this argument tends is significant. Price elasticity varies according to the different drugs, reflecting the degree of addiction triggered and speed at which addiction occurs. Further - as a new and general rule – Price Elasticity of Demand does not remain constant for any given drug.

Recognition that a sliding Price Elasticity of Demand exists for every drug (price elasticity is not constant for an addictive substance), that some price elasticities slide faster than others, and that all tend toward zero, are important realizations for public policy in a number of ways.

First, this argument casts a shadow over broad and unquestioned reliance – for public policy – on so-called "rational addict" research and so-called supply and demand model research. *The addicted person does not act rationally as the price elasticity falls, and this should be taken in to account when formulating policy.*[24] *Likewise, the market for addictive substances may behave very differently – especially for those addicted – than rationally clearing markets for non-addictive or less addictive substances.*

The "rational addict" notion attributes rational economic decision making to persons who are addicted to drugs, overlooking unavoidable effects on rational-actor decision making imposed by the dependence on drugs. Missing is the empirical fact that *addicted* persons, unable to freely choose *not* to use drugs, may not respond to price increases by lowering use.[25]

Similarly, the supply and demand models often do not take into account the one way effect of supply and demand for drugs on an addicted population; price and policies affecting price may deter first time or casual purchasers, but likely have little effect on addicted persons who are unable to exercise the option of not using, even when prices are high.

In summary, previous research on the relationship between prices and consumption, or between the price of an illegal drug (e.g. cocaine, heroin, marijuana) and the likelihood that it will be consumed, have missed a key element of that relationship. *The element missed is the non-applicability of market forces to narcotics and an addicted population.* Specifically, the behavior of addicted persons toward the market for drugs is tied to the effects of addiction upon their decision making. An expected change in consumption patterns, in response to changes in price may not materialize. Expected downward shifts in drug use based on higher prices may occur among first time purchasers, but be minimal or nonexistent among an addicted population. In short, the Price Elasticity of Demand does not stay the same for those who are first time purchasers and those who are addicted purchasers, and the slide from one to the other gradually sends the PED toward zero in virtually all cases.

Since the addicted person is caught in the downward spiral of addiction, public policies that are intended to discourage drug use by raising prices may have a dramatic positive effect on first time drug purchases, discouraging such use, while having little or no effect on use by the addicted population. *There would appear to be a significant need to complement such policy choices with sufficient accountable treatment to meet the needs of the addicted population untouched by the advantages of higher prices.*

Moreover, public policy decisions that encourage wider casual use – such as the reported eight percent or greater increase in casual use that might result from state or federal legalization of marijuana – would be likely to have a significant negative effect on the overall cost of state and federal health care (and related addiction costs), since

the fluctuating price elasticities associated with first time or casual ("luxury") use would quickly be replaced by the low elasticity of demand that attends use by an addicted population (as the drug creates dependencies that make it a "necessity").

The ordinary market demand and supply model and the so-called "rational addict" models are inadequate to explain the complex relationship, a sliding effect, between price and addiction. *The implications of this anomaly are significant. They mitigate against both legalization and decriminalization, since first time or non-addicted drug purchasers likely respond to higher prices by not initiating use and to lower prices by initiating use, but addicted persons do not respond in the same way.*

Among a larger addicted population, the lowering of prices would neither much increase nor much decrease drug use. Similarly, an increase in prices would neither much increase nor much decrease their use. The only deterrent with traction remains the incentive of effective treatment, to the extent that drug addicted persons retain an evaluative function and can be credited with a degree of rational decision making in response to this incentive, paired with the larger disincentive of serious, predictable and swift penalties, to the extent that major deterrents affect the decision making of addicted persons.

These are the tenets and conclusions discussed in this study. This paper is not intended to be either exhaustive or dispositive. The aim is to trigger further research and discussion of a fundamental – and commonly missed – element of the public policy debate surrounding both the need for treatment and the efficacy of attempts to lower the criminal penalties surrounding use of narcotics, based on the role of a sliding Price Elasticity of Demand for addictive substances.

Price Elasticity of Demand: What Is It and Why Does It Matter?

While an in-depth understanding of Price Elasticity of Demand is not required in order to grasp the importance of this concept in guiding public policy, a technical understanding is helpful. That having been said, a simple description is also the only starting point.

Price Elasticity of Demand is no more or less than the responsiveness of quantity of anything demanded (i.e., is more demanded or less?) to a change in price.[26] Typically, in order to make this tool useful, PED is used to measure a change in quantity demanded in response to an incremental up or down price change *in a given market during a given period of time.*[27]

The Technical Definition and Illustration

Price Elasticity of Demand is the "ratio of a proportional change in the quantity demanded of the good to the proportional change in price that brought it about [i.e., the change in demand]." More generally, "elasticity" is any "measure of the percentage change in one variable in respect of a percentage change in another variable ... Measures of elasticity tend to be carried out for very small changes in the variable causing the response – e.g., a percentage change in quantity due to a very small change in price."[28]

Another technical definition of Price Elasticity of Demand is "responsiveness of the quantity demanded of a good to its own price,"[29] thus "elasticity of demand is expressed as the percentage change in demand that occurs in response to a percentage change in price." The equation, where *Q = Quantity* and *P = Price,* is:

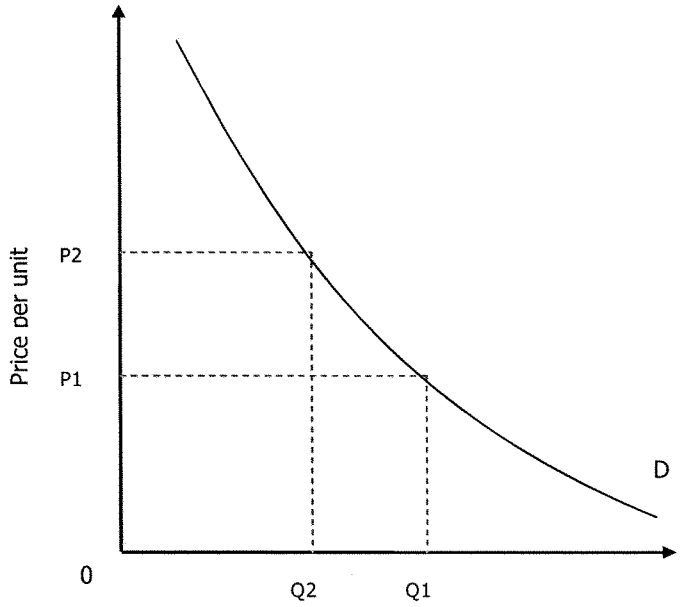
Price Elasticity of Demand =

$$\frac{(\text{Change in } Q/Q)}{(\text{Change in } P/P)} \cdot \frac{100}{100} \quad \text{(OR)} \quad \frac{\text{Change in } Q}{Q} \cdot \frac{P}{\text{Change in } P}$$

Demand is said to be *elastic* if Price Elasticity of Demand (often represented by *e,* as the coefficient of Price Elasticity of Demand, but represented here as PED) is greater than 1, *inelastic* if less than 1 and *unitary* if equal to 1. The point being conveyed is that change is either greater or less than one, and "if the absolute value of the price elasticity of demand for a good is equal to one, then expenditure on the good does not change as its price changes." [30]

Several other economic terms may help explain progression of purchasers of addictive substances from first use to addiction. One concept is "preference," a term used by economists to mean that a consumer may "prefer" one good to another good

The Basic PED Graph



Price elasticity of demand (PED)*

The responsiveness of the quantity demanded to a change in price in a given market during a given time period, ceteris paribus. It is measured by the percentage change in quantity demanded divided by the percentage change in the good's own price. In the diagram the PED for a price rise from OP1 to OP2 would be measured as: (OQ2 – OQ1)/OQ1 + (OP2 – OP1)/OP1

The resulting value will be negative since when price rises, the quantity demanded falls (i.e. the demand curve slopes downwards from left to right). This method is known as arc elasticity because it measures the responsiveness over the range of prices between OP1 and OP2. By reducing the change in price to an infinitesimal amount, the PED at one point on the demand curve can be calculated. Point elasticity demonstrates clearly that PED depends not only on the ratio of the original price and quantity. Thus, in all but exceptional cases, the PED is different at every point along the demand curve.

* Daithtith, J. (Ed.), ***Letts Dictionary of Economics*** (London, 1983): 140.

or good(s), allowing a *preference function* to establish an *ordering* of such preferences. Notably, there is an assumption that the consumer is exercising rational choice when making his preference known by consuming one good over another. In other words, if an individual prefers X to Y, one can say that the utility the individual derives from X is greater than from Y.

"Utility," in turn, is a term "widely construed in economics to be synonymous with 'welfare.' ... although understood by some economists to mean benefit." The difference of opinion is important. An addicted person perceives that his addiction at the time of consumption is maximizing "utility," where that term is defined as short-term benefit. Yet most observers would strenuously dispute the assertion that an addict's dependence and tolerance for a drug – leading to greater consumption – is maximizing his welfare.

Referring to an individual's "utility function" is one way of describing that a consumer's perceived "utility is dependent upon the goods he consumes and their amounts." By way of an equation, if U = Utility and X, Y, and Z are the types and amounts of goods in question, the individual's utility function is U = U(X, Y, Z ...) For addicted purchasers, the utility function tends to minimize other commodities as it is increasingly defined by proportional and absolute increases in consumption of the addictive substance.

Several Common Sense Applications

Outside the world of drug policy, one might seek to prove that an upward price change constituting 50 percent of the baseline price (e.g. a jump in the price for all brands of disposable diapers from one dollar to one dollar and fifty cents per diaper) produces a net reduction in sales of only 10 percent. This would prove disposable diapers to be a relatively *inelastic* commodity, since the PED clearly indicates that diaper buyers just will not do without them, even when the commodity jumps in price. Low elasticities might also attach to such predictably necessary commodities as oil, gas, sugar, salt and toilet paper. The percentage change in amount demanded divided by the percentage change in price yields a number, describing the exact Price Elasticity of Demand. What matters most, however, is whether the changes in price upwards or downwards tend to alter, in similar or different ways, purchasing of the commodity.

By converse example, an upward price change of only five percent in the cost of one of a dozen similar breakfast cereals may yield an immediate switch by 80 percent of the buyers of that cereal to one of the other nearly identical, equally available, but cheaper brands.[31] This commodity would be described as having a high elasticity of demand.

Several Basic Clarifications

Before applying this concept to drug policy and reviewing current literature on the topic, a few clarifications may be helpful. There are several types of elasticity, including point elasticity of demand, arc elasticity of demand, cross elasticity of demand, elasticity of income and elasticity of supply. There are also limitations on the value of price elasticity, where other factors matter more to the consumer than price.

In general, price elasticity measures the effect of price change on changes in quantity consumed. To do this, economists hold all other factors equal or unchanged, as they seek to isolate the impact of a price change alone on the quantity purchased. In reality, this is nearly impossible. Many factors can affect the quantity consumed, and price may yield a very small effect.

"Point elasticity" is essentially the quantity change at a new price where the change is very small.[32] More specifically, it is the "coefficient of price elasticity of demand at a particular point on a demand curve."[33] "Arc elasticity" is an estimate of elasticity over an arc between two points on the demand curve. Specifically, arc elasticity is the "coefficient of price elasticity of demand between two points on a demand curve" (creating an arc on the graph).[34] It is an estimate based on significant change over a period of time, the accuracy of which improves as the arc becomes smaller. Notably, the basic "demand curve" plots price (Y-axis) against quantity demanded (X-axis). "By varying the price of the commodity under consideration, while keeping constant the individual's money income and tastes and the prices of other commodities ... [one gets] the individual's demand schedule for the commodity." A graph of an individual's demand schedule is the "demand curve," typically running from upper left to lower right.

"Cross elasticity of demand" refers to the effect of changes in price of one product on the quantity purchased of a second product in a set time, taking into account substitutes and complements. Thus, cross elasticity is the "ratio of the percentage change in the amount of commodity X purchased per unit of time to the percentage change in the price of commodity Y."[35] In other words, if the price of one manufacturer's cars increases markedly in a short period of time, how does that affect the quantity of cars purchased from other manufacturers (i.e. substitutes)? At the same time, how does the price increase affect the complementary products that are dependent on that manufacturer's model for their own sales (i.e. complements)? In the world of narcotics, if heroin becomes highly expensive or hard to acquire, what impact does this have on sales of a drug with parallel effects, such as OxyContin? What effect does a price increase for heroin have on sellers of needles?

"Income elasticity of demand" is the "ratio of the percentage change in the amount of a commodity purchased per unit of time to the percentage change in the consumer's income."[36] If the economy dips into recession and, holding other factors

constant, potential first time purchasers have less disposable income, how does this affect the rates of initiation? If potential first time purchasers experience marked increases in disposable income, what effect does this have on first time use?

Finally, "price elasticity of supply" refers to the "ratio of the percentage change in the quantity of a commodity supplied per unit of time to the percentage change in the price of the commodity."[37] Thus, in the context of narcotics, if Western states have a substantial supply of Mexican methamphetamines and Eastern states have a substantial supply of Colombian heroin, what effect does that have on prices for these drugs, respectively, in those states? What effect does the lower quantity of the same drug on the opposite coast have on price? What effect would a substantial reduction in supply of either drug have on the prices in the states where it now is prevalent?

Over an extended period, there is often the assumption that price elasticity of a given product remains relatively constant, even as price changes are large and quantity consumed varies with the price changes. Often, the consumer of the product is assumed not to change the degree of need for that product over the period between measurement of two "point elasticities," and is further assumed to exercise rational decision making in a consistent way over time to explain the changing amount purchased at two different prices. This may not be true, and certainly appears unlikely in the case of first time purchasers of addictive drugs who subsequently become addicted. No model of continuously shifting or sliding price elasticities for different drugs has been offered, and none has been studied by reference to any longitudinal data set.

Similarly, there is less overall importance attached to the actual price elasticity than to the "relative" elasticity of commodities. Thus an "ordinal" approach to measuring a product's price elasticity may be most valuable. Gordon Hewitt, in his classic ***Economics of the Market***, describes the importance of "relative elasticities" this way:

> The concept of Price Elasticity of Demand is used to compare the response in quantity demanded of a good to different price changes, or alternatively to compare the response in quantity demanded of different products to a specific proportionate change in price ... When a variation in price leads to a greater than proportionate change in quantity, demand is said to be relatively elastic ... In such cases, the price elasticity will be greater than one ... Hence if the price of [any commodity] changed from 5 [dollars] to 4 [dollars], the demand for [that product] would be *relatively elastic*.[38]

The same could be said by flipping the example. "Alternatively, when the proportionate change in quantity demanded is less than the proportionate change in price, demand is said to be *relatively inelastic* (emphasis added)."[39]

Many traditional economic texts treat price elasticity as a set quantity change for a given price change in a product or commodity. They do not review longitudinal data for a purchaser group to see if there is a changing or "sliding" price elasticity for the same substance by the same consumer group over time, and thus do not address the concept. Thus, Hewitt concludes, "when demand is relatively elastic, a fall in price will lead to an increase in total revenue [for whoever the seller is], and a rise in price will lead to a fall in total revenue [for the seller]."[40] At the same time, his work holds that "when demand is relatively inelastic, a fall in price results in a fall in total revenue, and a rise in price results in a rise in total revenue."[41]

As accurate as these statements are for non-addictive goods or products, missing from this analysis is the notion that a commodity may begin at a high price elasticity and slide rapidly from "luxury" status to "necessity" status, bringing with it a sudden drop toward a lower PED.

The Idea of Sliding PEDs and Addiction

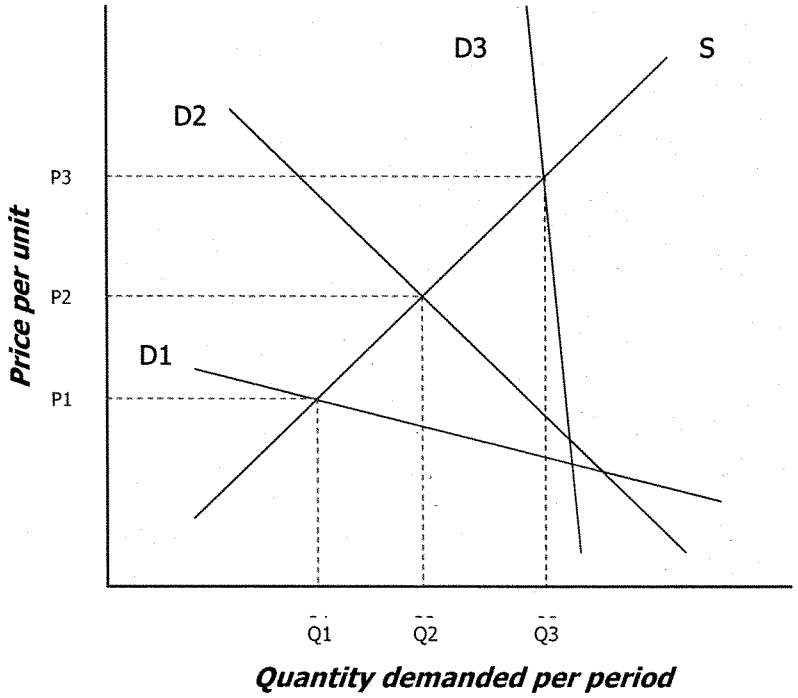
Turning to drug policy, if one assumes that addiction represents an unchanging or rising demand for the commodity at issue, namely a narcotic, the evolution from a highly *elastic* quality to a highly *inelastic* quality is represented by another principle of price elasticities. *A vertical line on a chart plotting changes in price (vertical axis) against change in quantity (horizontal axis) would represent what is called "perfect inelasticity." This is the ultimate state that describes drug addiction, and the state toward which casual users often drift as they become psychologically or physically addicted to a drug.*

Why is this so? The reason, in economic terms, is simple. "By inspecting [a vertical] demand curve, it can be seen that quantity demanded always remains the same ... at all price levels. [That is,] if we computed the value of Price Elasticity of Demand for *any price change*, the numerator in our formula would always be zero since *no change in quantity demanded takes place*. Hence the value of Price Elasticity of Demand would be zero over all parts of the demand curve. When a price change results in no change in quantity demanded, demand is said to be perfectly inelastic (emphasis added)."[42]

Bingo! The evolution of an illicit drug user from first time experimentation to hardened addiction can be aptly represented by the shift from a responsive or price elastic product to a highly inelastic product. What the literature on non-addictive substances does not account for is the central fact behind addiction: it is not the product that has changed, but the consumer's behavior toward that particular product. Specifically, what has changed is the increasingly addicted consumer's unwillingness to reduce demand for that particular narcotic, even when price rises.[43]

As the price elasticity has gone from high to low, the curve (plotting vertical

Progressive Drop in Price Elasticity of Demand Over Time Associated with Narcotics Use



- Demand is highly elastic (shallow slope) at first use of a narcotic (*D1*): a slight increase in price has substantial impact on demand, *ceteris paribus*.
- Demand becomes less elastic (increased slope) with casual use of a narcotic (*D2*): a price increase has less effect on demand, *ceteris paribus*. Note also that as narcotic use increases, the addictive characteristics of the narcotic increase the demand for the narcotic at all prices, thus shifting the demand curve to the right (*D1 to D2*).
- Demand becomes highly inelastic (steep slope) with addiction to a narcotic (*D3*): a price change has very little or no impact on demand, *ceteris paribus*. Again, as use increases, demand for the narcotic increases at all prices, shifting the demand curve further to the right (*D2 to D3*).
- Over time, from first use (*Q1*) to addiction (*Q3*), the quantity of an addictive narcotic demanded by an addict increases at all prices, and the demand for the narcotic becomes less elastic.

price against horizontal quantity) has gone from one that reflected *sensitivity to price* to one that *ignores price*, from a more horizontal line (left downward toward the right) to a vertical line, representing the inescapable clutches of a perfectly inelastic product. The purchaser is no longer able to choose not to purchase when the price rises infinitely, but rather is compelled to find the resources to obtain the drug to which he or she has become addicted.[44]

In economic terms, the slide toward perfectly inelastic demand is significant. It confirms that, for narcotics or any highly addictive commodity, intervention to restore rational decision making is *essential*, since without a means for ending the addictive behavior which keeps PED inelastic, only death of the addicted person or complete absence of both the addictive commodity *and* any substitute will end the addiction.

Applying the Sliding PED to Legalization: A First Look

Equally poignant is the other application of PED to drug policy. If addiction can be explained in economic terms as a vertical line on the PED chart, or demand that is "perfectly inelastic" absent intervention, there is also a way to illustrate the economic effect of low price spurring theoretically infinite purchases.

A horizontal line at some very low price point on the same chart would indicate that there was a price level at which even first time drug buyers - presumably uninhibited by education, prevention, or knowledge of the risks incurred by the purchase - would feel inclined to "buy all they could possibly get [or at least use] at that price."[45] This line represents "perfect elasticity" since, at any price above that price line, the consumer would be less inclined (or disinclined) to buy the narcotic. However, at a lower price, a first time purchaser is more inclined to purchase the commodity.

Why does any of this matter? The theory behind PED is that one can measure the impact of price on quantity purchased. While the literature has come up short on the measurement of an evolving or sliding PED for addictive substances (e.g., narcotics) and seems not yet to recognize a particular ordinal or relative ordering of the speed with which addiction occurs or speed with which PEDs change for different addictive substances, there is a genuine need for further research into what public policies follow from 1) the possibility of a sliding PED for an addictive substance, and 2) the speed with which different addictive substances shift from high price elasticity to low price elasticity.

This research and *mere recognition of sliding PEDs for various addictive substances* as an important element of the public policy debate is sufficient reason to study further the described phenomenon.

If narcotics or addictive substances generally are characterized by a sliding PED, then there is every economic reason to oppose policies such as decriminalization or

legalization of such substances, since they would tend to be rapidly purchased at lower prices, but would soon drive new purchasers of the addictive commodity toward "perfectly inelastic" demand, that is, addiction.

To the extent that addiction is a state of consumption carrying increased economic costs in medical response, reduced productivity, domestic violence response and related economic requirements on governments, policy movement in this direction is likely to increase the economic drain on any government that adopts a position of encouraging such consumption of substances characterized by a sliding PED.[46]

In short, legalizing presently illegal and addictive commodities would predictably lower price and encourage wider first time use, triggering the onset of a larger number of consumers who are unable to avoid consumption at any price in the future. A policy that encouraged addiction, or a shift toward wider first time use and thus wider addictive consumption, would tend to cascade toward increasing addiction with all the concomitant costs of this widening within of addiction within society (see discussion in ***Notes and References***, #46).

While not all consumers would be expected to respond to the lower price of the addictive substance, and education and prevention might mitigate the effects of heightened availability, legalizing (i.e., lowering the cost of) that substance would likely lead to an increase in use, and the rate of slide for PED of each particular substance legalized would dictate how great the increase in economic cost would be to the government embracing that policy.

In short, additional research into the unique characteristics of a range of addictive substances in economic terms, including drug and alcohol-related PED research,[47] and in particular the concept of sliding PEDs and the rate at which they shift from high to low for each particular drug, would appear to be of considerable value for public policymakers.

Research Needed on Sliding PED Model

This point is driven home by one recent analysis of addiction and economics. In the 2001 study entitled ***Informing America's Policy on Illegal Drugs***, the National Research Council details weaknesses in "estimating demand functions and price elasticities" as they related to drug abuse.[48] While noting that "demand functions and price elasticities must be understood to formulate effective drug policies,"[49] the authors criticize existing studies in this area for nine reasons. These reasons are lack of reliable price data, price dispersion, other costs, lack of quantity data, addiction, heterogeneity of consumers, cross-elasticities, the dynamics of drug use, and heterogeneity of drugs.[50] While each of these criticisms of current economic research relating to PED may be valid, some stand out.

The notion that better data is needed to describe the actual prices at which drugs are purchased, actual costs incurred by consumers, how much of which drugs are purchased, what the purity of various drugs is and how often drugs are substituted for one another are all valid concerns. Generally, these criticisms point toward a need for better data collection. More importantly, however, are criticisms that dovetail well with this study's argument for measuring and charting different sliding PEDs for different drugs over the lifetime of a user population.

Specific criticisms lofted by the National Research Council reinforce points made in this study. First, too few longitudinal studies have been done on addiction, measuring the relationship between drug use, price and the effects of addiction over time for one user population. Second, different consumers of the same addictive drug may react differently to price. Thus, "cocaine consumers include casual and heavy users ... These two groups face similar prices (or distributions of prices) but have very different consumption patterns."[51]

The problem of not recognizing that casual and addicted purchasers consume in different ways is consistent with the argument that researchers should focus on the notion of a *sliding Price Elasticity of Demand* for different stages of drug consumption. As the National Research Council accurately points out: "Casual users may be more responsive to changes in prices [and in fact are] than heavy users ... If so, the high elasticities of participation [i.e., use of any kind] found in recent studies of demand may mainly reflect responses of casual users to price fluctuations ... In addition, the finding that frequency of use ... is less responsive to price ... may be strongly influenced by the behavior of heavy (high frequency) users who are relatively insensitive to price changes." Revealingly, the Council notes: "No demand model that the committee has seen allows for the possibility that casual and heavy users have different price sensitivities."

Likewise, this critique of economic literature points out what is missing. It notes that there is little research modeling "dynamic" drug use, explaining effectively the relationship between price, time and use of drugs by one addicted population, and there is no data to model this idea. "No existing empirical model of demand for drugs describes the process by which individuals initiate and make transitions among different levels of drug use (e.g. from nonuse to casual use, from casual use to nonuse or heavy use)," noting that "the data that are required for empirical study [of such a model] of drug use dynamics and their dependence on prices and other costs of drug use are not available to researchers ... Implementation of such a study would require a longitudinal data set that describes drug use by individuals over time."[52] These points are well taken.

Even if the proper model is comparative "sliding Price Elasticities of Demand" for different drugs over time by one user population – the absence of data will remain a problem. Nevertheless, the need to articulate such a model and collect the data to

support it is becoming increasingly clear.

On balance, while a variety of studies have looked at narcotics as an economic commodity, most have sought to treat addictive substances in terms which apply to consumer behavior generally, such as imputing a static PED to a given commodity or applying a so-called "behavioral economic" approach to the question of drug consumption.

Generally, these studies seek to explain consumption by reference to a variety of factors, such as income level, socio-economic factors, work or cost of obtaining the drug, availability of the drug and availability of substitutes.[53]

In summary, these studies see addictive substances as economic commodities that, in general, conform to traditional notions of price and income elasticity of demand, or "supply and demand." Even when the notion of Price Elasticity of Demand has been applied, and found for example to support a highly inelastic PED for cocaine among addicted persons, the idea has been premised on a constant – not sliding – variable, and recourse to a dynamic model or longitudinal data has been missing.[54]

Survey of Literature on Economics of Addiction: Good, Bad and Ugly

A wide range of literature exists describing the economics – and putative economics – of human addiction, narcotics sales, incentives and disincentives, penalties and prohibitions, supply reduction, demand reduction, treatment modalities and prevention effects.

A substantial cross-section of this literature was collected and analyzed in an effort to synthesize and account for *the leading economic arguments and studies* in the field that might bear on this project. Reviewing all literature describing itself as economic or bearing on economics of these issues was beyond the scope of this project. In effect, there exists a set of repeating arguments which tend to surface under the rubric of economic analysis. These appear in journals as readable as ***The Economist*** and as arcane as the ***Eastern Economic Journal***. A representative cross-section of this research is assessed in this paper.

Overview of Economic Literature on Addiction

Some articles and research presented in journals of higher learning are highly valuable pointers, rigorous in their methodology and deserving of special mention. Hundreds of others are thinly veiled excuses for unsubstantiated opinion and offer no new economic ideas upon which to make decisions or base future policies or research.

In an effort to fairly account for leading economic research surrounding the topic discussed in this paper, a description of several studies and research efforts of note is set forth in this document. These studies only buttress the notion *that sliding PEDs for drugs are important and their application to particular drugs is an unexplored avenue with significant policy and research implications.*

Less time is devoted to those studies which offer only cursory or unoriginal assessments of the economic factors at play in discussing the Price Elasticity of Demand for addictive substances. No time is allotted to discussions that range far outside the economics of PEDs for addictive substances, unless they materially address factors that might affect the PEDs of such substances.

Encouragingly, some studies of addictive substances have recognized that Price Elasticity of Demand may have valuable application to the science and policies surrounding substance abuse and addiction. Unfortunately, these studies have been largely dedicated to other matters, self-limited, incomplete and often conclude with such simplistic assessments as, for example, "there is a palpable demand curve for substances with a sizable price elasticity."[55]

While this is a good starting place, such statements fail to pursue the best use

of that economic tool. They do not recognize, establish, track or make useful follow-up observations about the application of sliding PEDs to addictive substances. Missing is an understanding that the PED for a highly addictive substance does not remain constant, but is dynamic – invariably shifting for any given purchaser and for each type of drug. This understanding is central to effective public policy, since there will be a predictable attenuation of any effect that price has on quantity consumed based on the frequency of use and level of addiction.

On PED itself, as indicated earlier, existing research tends to suggest either that drug consumption is steady at one rate highly responsive to price or steady at one rate that is highly nonresponsive to price.[56] In only two studies are specific points or regions identified at which different Price Elasticities of Demand exist; both record a high sensitivity to price among "dabblers" and a low sensitivity to price among addicted persons.[57] *Missing are the notions that Price Elasticity of Demand invariably slides over time for purchasers of all drugs, that different drugs have different rates of slide or sliding price elasticities of demand, and that this dynamic reality directly affects a society's public policy choices.*

Reviewing "Rational Addict" Theory

Many studies on economics and addiction acknowledge that "prices are an important determinant of demand for addictive or psychoactive substances – whether they be alcohol, cigarettes, snuff, cocaine or valium ...."[58] Generally, these studies recognize that price is an effective tool for regulating demand only when purchasers are willing and able to respond *rationally* to changes in price. On the other hand, some studies suggest that addicted persons act *rationally*, calculating how to maximize utility over the long run by measured consumption and a thoughtful feeding of their addiction.

A review of leading economic arguments and recent addiction studies, suggests that the decision making by addicted persons is not rational, but compulsive. Reason and long-run calculations are replaced by growing dependence on, need for and tolerance of the addictive narcotic.

At the core of the PED discussion is the fact that addicted persons do not typically react to price changes in the same way as nonaddicted persons. While drugs are consumed by first time and casual purchasers *more often at lower prices (and less often at higher prices)*, these same drugs are consumed by addicted persons with *little change in quantity and low sensitivity to price.* Notwithstanding these observations and the science of addiction, some researchers propose that addicted persons calculate long-term utility as rational consumers – in short, they are "rational addicts."

Persistent references to "rational addict" behavior invite a closer look at this idea and at *the nature of addiction*. In general, the notion that "rational addicts

should not require paternalistic rationing [by the government or anti-drug laws] of their [narcotic] consumption"[59] has little support in either the economic or addiction literature.

On its face, "rational" decision making is not a characteristic matching the compulsive and dependent nature of addiction.[60] On the contrary, a growing body of research supports the "cognitive deficits" model of addiction. This model sees a *departure from rational decision making* by those addicted to drugs.

Specifically, "[t]he cognitive deficits model of drug addiction proposes that individuals who develop addictive disorders have abnormalities in an area of the brain called the prefrontal cortex (PFC) ...The PFC is important for regulation of judgment, planning, and other executive functions ... [A]s a result, they have reduced ability to use judgment to restrain their impulses and are predisposed to compulsive drug-taking behaviors. Consistent with this model, stimulant drugs such as methamphetamine appear to damage the specific brain circuit – the frontostriatal loop – that carries inhibitory signals from the PFC to the mesolimbic reward system."[61] In lay terms, "[d]rugs of abuse, such as cocaine, also appear to cause long-term physical alterations in the brain that may make it very difficult for [addicted persons] to merely change their minds about using drugs."[62]

More to the point, although there are conflicts in the literature, a substantial body of research supports the bald assessment that "addiction is irrational in the sense that it is not curtailed by the aversive effects of drugs."[63]

Another element of "rational addiction" theory requires a mention. To argue – as some do – that addicted persons should not have their supply of drugs curtailed by the government, but need help from the government to rationally "optimize" their "lifetime utility" as the addicted persons is, at best, "a circular argument."[64] As one observer put it, even if price had an effect on addicted outcomes, "at the end of the day, fairly large price elasticities [among a group of drug purchasers] does not constitute proof of rational addiction [within that group]."[65] While first time and occasional purchasers may demonstrate sensitivity to price, addicted persons are less likely to have their consumption change in response to price, reflecting a departure from rational decision making well documented by the cognitive deficits model.

One further study of interest in this area is a 1998 "rational addiction" study by Grossman, Chaloupka and Sirtalan, published in ***Economic Inquiry*** and entitled "An Empirical Analysis of Alcohol Addiction: Results from the ***Monitoring the Future*** Panels."[66] While the study assesses the "short-term" and "long-term" effects of price on consumption of alcohol, comparing these with those for cigarettes, the reference to PED is less valuable than hoped. As with other studies of this type, this study assumes rational decision-making by those already addicted. Moreover, the authors refer to "elasticity of consumption," a term not familiar or commonly recognized in leading eco-

nomic texts,[67] rather than price or cross elasticities of demand. To the extent that the authors intend to compare variations in Price Elasticity of Demand over a short-run period and a long-run period, the findings are unclear.

On the other hand, the rigor of the comparison is unusual, and one of the authors' findings may help in creating an ordinal system for comparing sliding PEDs for different drugs. Specifically, the authors find that "alcohol consumption is somewhat less addictive than cigarette smoking."[68]

On balance, the "rational addiction" model seems to dispose too quickly of the mind altering nature and effects of addiction, while providing support for the relative addictiveness of different substances.

High Prices Have Limited Effect on Consumption by Addicted Persons

Another recent analysis illustrates that high prices may have less effect than frequently thought upon consumption by addicted persons. This 2001 study compares cigarette consumption in high-tax states with cigarette consumption in low-tax states.[69] The study notes that researchers attributing lower cigarette use in the high-tax states to the upward pressure on prices fail to account for the anti-cigarette bias pre-existing in many high-tax states. Thus, comparatively lower cigarette use numbers in such states do not imply that addiction can be reduced - even in the case of a milder addiction - by raising prices. In summary, the link between prices and behavior change for those who are already addicted is highly attenuated.

In the view of these researchers, antidrug education is far more compelling as an agent of behavioral change than price. Specifically, while many studies have corroborated that "anti-smoking regulations, anti-smoking education campaigns and less obviously formal education" have "often been found to reduce smoking, and more generally to increase healthy behavior," the same is not true for higher prices associated with an increase in cigarette taxes.

Without separating addicted persons from occasional purchasers, this study found that:

> There is a potential bias in cross-sectional estimates of the effects of cigarette prices on cigarette consumption. States with the strongest antismoking sentiment will likely have the highest cigarette taxes, which result in the highest prices. Some of the lower consumption of cigarettes in high-tax states will result from such sentiments, rather than from higher taxes, so the estimated effect of cigarette taxes on consumption will be overstated. This study corrects for such bias, employing panel data ... from 1960 to 1990. *We find that controlling for this bias reduces the estimated consumer response to cigarette price change by 40 to 50 percent* (emphasis added).[70]

In fact, if the overstatement is this high, the real effect of price on those addicted may be very low. The real impact of price, even on those addicted to cigarettes, may be closer to zero or characterized by an extremely low PED.

Note that there is a series of historical PED data cited in the foregoing study, but none of the studies cited addresses the issue of a sliding or shifting PED for specific drugs over an extended period. Instead, this data refers to a variety of different PEDs for different purchasers and the notion that "long run" PED is generally low for addictive substances. Missing are policy implications of a shift from a high to low PED, tracking an addict's progression from first use to addiction. Moreover, decision making by individual addicted persons is not studied; only collective behavior of all users – nonaddicted and addicted – is studied.[71] *What this study suggests is that price may be less significant for those who are addicted – even to nicotine – than originally thought, and also less important to decision making of addicted persons than education.*

This finding reinforces the thesis that sliding PEDs matter and that an addicted population may not respond to a price change the way a first time purchaser would respond to the same price change. One added voice for this thesis, while not addressing sliding PEDs for addictive substances, is an economic study published by ***The Columbia Law Review*** in 2000. In that study, the author argued that "[t]he concept of 'elasticity of demand' [citation omitted] is also important to the traditional law and economics argument ... When the elasticity of demand for a particular drug is low, increasing the price ... will have a relatively limited effect on consumption."[72] In short, if the PED for any drug is low among the addicted population, changes in price will have "a relatively limited effect on consumption."

Again, this forces the conclusion that public policies intended to address addiction through a simple upward price change in the addictive substance will not succeed; while policies which would legalize a drug, lowering the price, might produce new first time purchasers and, over time, create a larger population of addicted persons.

Studies Fail to Separate Price Impacts on Nonpurchasers, Occasional Purchasers and Addicted Purchasers

Often studies with considerable economic depth miss the fine points of addiction. Thus, for example, one study published in 2001 mentions Price Elasticity of Demand and seeks to estimate the effect of state criminal justice and public health spending on deterring illicit drug use.[73] Unfortunately, the authors fail to separately analyze the behaviors of nonpurchasers, occasional purchasers and addicted purchasers. The effect of this omission is to minimize the impact of the findings.

As with other studies, these authors premise their work on the assumption that the laws of "supply and demand" work both for addictive and non-addictive substances.[74] Specifically, the study "assumes a demand function that is downward sloping

with respect to price and a supply function that is horizontal or upward sloping with respect to price." In short, changes in price are *assumed* to affect both "supply and demand" at any level and at any time, producing a traditional, proportional and predictable effect on one another. There is no attention to the possibility that price and supply changes may affect demand of a subgroup differently from the whole.

With partial accuracy, the study finds that "criminal justice spending directed at drug dealers may increase the cost of doing business, which would raise the price of illicit drugs and reduce drug use ... [Thus] [c]riminal justice spending directed at users may shift the demand curve to the left, which would reduce drug use and drug prices."[75]

While increased costs do generally get passed to the consumer through higher prices, the notion that first time drug purchasers, occasional drug purchasers and addicted drug purchasers respond similarly – much less equally – to a rise in the price of an addictive substance is neither substantiated nor addressed.

The more likely conclusion is that first time and occasional purchasers, not yet addicted and therefore not yet unresponsive to price changes, will react to a rise in prices by reducing demand. On the other hand, addicted consumers will not respond swiftly – if at all – to a rise in prices, since to them the quantity needed (i.e., to be demanded) is unchanged.

The study also states that "the effect of a given expenditure on criminal justice or public health is dependent on the magnitude of the resulting shifts in the two functions and the supply and demand price elasticities." Subsequently, the study argues that "four recent empirical studies provide evidence that drug use is responsive to market forces."[76]

Notably, not one of the four studies cited disaggregates the *addicted* persons and *nonaddicted* populations, or addresses the idea that a sliding Price Elasticity of Demand for addictive substances may exist – and may affect their findings. Instead, each study lumps together first time, occasional and addicted purchasers, and concludes generally that demand within this disaggregated market changes when prices change.[77]

While there is wide acceptance of the idea that price increases reduce demand for those who are not addicted and price declines spur increases in demand,[78] there is no evidence offered – in this study or any of the four cited – to support the argument that addicted persons are similarly responsive to a rise in prices, that is, by reducing their demand. Further, there is not any evidence presented that demand remains similarly responsive to price when first time users migrate to occasional purchases and eventually to addictive purchasing, in effect producing the sliding Price Elasticity of Demand.

Perhaps most revealing is this study's confession that the data sets used, while large and thus likely to be more reliable, nevertheless aggregate all persons who come into contact with drugs; the authors recognize that the data sets do not separate responses of those who are *occasional* purchasers from those who are *addicted* purchasers. "Although there is no strict dichotomy between occasional and frequent drug users, these surveys are likely to be more representative of occasional drug users rather than frequent drug users...[and when measuring past year drug use, the dependent variable] does not differentiate between recreational and habitual drug users ... Because the [study's data sets] are more representative of recreational drug users [undefined], the effects may be strongest for this group."[79]

Nevertheless, this study does reach at least one finding that crosses all purchaser populations. By reference to regression analysis, the authors conclude in general: "[m]arijuana decriminalization is ... found to increase drug use."[80] This finding is consistent with the view that first time drug use rises as availability increases, and that availability increases with legalization or decriminalization of an addictive substance.[81]

What would have been instructive is 1) an assessment of the changes in marijuana price as the decriminalization occurred, and 2) an assessment of the changes in addiction rate over an extended period in those states that decriminalized or legalized this (or any other) narcotic.

Still, this study stands for the propositions that 1) leading research often does not disaggregate first time purchasers, occasional purchasers and addicted purchasers when discussing the impact of price changes on consumption, and 2) at least for marijuana, decriminalization (presumably reducing price for all purchaser groups) increases overall use for the disaggregated purchaser population.

Changes in Price Affect Drug Initiation Rates

Another study of note was reported in the ***American Journal of Public Health*** in 1998. The key to this study was "trends in initiation of psychoactive drug use."[82] *One essential conclusion drawn from this data analysis was that "changes in price can significantly affect initiation [of drug use]."*[83] *In other words, lower prices may increase initiation and higher prices may reduce initiation.*

Specifically addressing "marijuana, cocaine and hallucinogens," the study states that "demand does respond to price shifts in such markets."[84] The study does not identify whether this change in demand was among those "initiating" or among those who define themselves as frequent purchasers. Nevertheless, this study concludes that, "changes in price can significantly affect initiation [of drug use]."[85] The likely link between these two findings is that initiation rates – or rates of first use – for any drug are affected by price, while substantial price effects are not recognized for those already addicted. Other economic studies confirm the link between drug price and drug initiation rates.[86]

Distinguishing between Decision Making by Addicted and Nonaddicted Persons: Price and Tax Hikes Offer Limited Utility for Reducing Consumption by Addicted Persons

A sixth recent study has special value for this analysis. Licari and Meier offer a 1997 study in the ***Political Research Quarterly*** entitled "Regulatory Policy When Behavior is Addictive: Smoking, Cigarette Taxes and Bootlegging."[87] Among the meaningful conclusions this study draws are the following:

First, while premising their research on the applicability of supply and demand principles in the addictive environment,[88] they acknowledge the significance of low Price Elasticity of Demand for the addictive commodity cigarettes. They state that: "Although the price elasticity of cigarettes may be sluggish because they [cigarettes] are an addictive commodity, at the margins higher prices should reduce demand." This statement is quite revealing. While cigarettes are a modestly addictive substance by comparison to substances with higher abusive potencies, such as heroin and methamphetamine, the study recognizes that the addicted consumer will behave differently from the non-addicted consumer. Additionally, the authors recognize that the value of high prices in an addictive market – even one that is relatively less addictive than commodities with higher abusive potencies – is limited as a tool of public policy for addressing addiction.

Second, the authors clearly articulate the dilemma presented by using *taxes* – that is, an artificial increase in price – as a tool of public policy for conflicting purposes, raising revenue and reducing consumption of the addictive substance:

> Faced with an increase in taxes, a smoker [or other addict] has three options: (1) continue to smoke [or use] and pay the tax; (2) reduce consumption and pay less taxes; or (3) attempt to avoid the tax, possibly by bootlegging [i.e. illegal acquisition of the commodity at a lower price]. If the state government's goal is to raise revenue, it prefers the citizen select option (1) and not options (2) or (3). If the goal is to reduce consumption, then the government would like the smoker [or user] to select option (2) but not options (1) or (3). Whatever the state's goals, however, option (3) undercuts them.[89]

The 1997 Licari study offers important points worth attention. The study suggests that price effects on an addict's demand for a drug may be accounted for by "a statistical model ... [that will] lag the dependent variable." In essence, this means that the authors believe – as do the other investigators who have explored this idea – that they can account for the "stickiness" of supply and demand in the addiction context by a statistical trick. They recognize that the addicted individual is less likely to respond to higher prices as he or she becomes more addicted, undercutting the normal operation of the laws of supply and demand.

To compensate for the obvious inapplicability of supply and demand, they offer to lag – or add back into the equation – past consumption of the addictive substance. That is, they will slow the responsiveness of the addicted individual to price changes in proportion to the number of years (or months) he or she has been addicted. In this way, they hope to prove that price still affects behavior, but to also acknowledge that price affects behavior of addicted consumers less and less each year.[90]

There are several problems with this "lagged dependent variable" answer to the problem of addictive nonresponse to price. Lagging the dependent variable assumes a steady rate of addiction, requires speculation as to how much lag to permit (i.e., how addictive the drug is year to year), and fails to account for an end state often quickly – not gradually - reached, in which price no longer affects consumption patterns by an addicted person, since the need to consume is not reduced or rationally deflected by higher prices.

Nevertheless, one redeeming feature of the lagged dependent variable analysis in this study is the recognition it implies of the nonresponsiveness of addicted persons to price changes. Specifically, the study notes, but fails to quantify, the rising PED for drugs as purchaser addiction grows: "[s]ince the nicotine in tobacco is highly addictive, current consumption levels are highly dependent on prior consumption levels [citation omitted], and the responsiveness of demand to price (or tax) increases and policy changes should demonstrate some stickiness"[91]

Studying alcohol use at college age is instructive in other ways. One intriguing study is the 1996 analysis by Chaloupka and Wechsler, entitled "Binge Drinking in College: The Impact of Price, Availability, and Alcohol Control Policies," in ***Contemporary Economic Policy***.[92]

While the conclusions are limited for decision making by addicted persons, they suggest that alcohol use in the form of "binge drinking" by college age males may have a very low response to price, reflecting a low Price Elasticity of Demand. *In this way, "binge drinking" may be closely correlated with addictive behavior.* One problem with this study is that there is no data set uninfluenced by widespread availability of free, underpriced or unpriced alcohol, especially beer, on college campuses. Accordingly, the reference to prices in the community may be spurious.

On the other hand, the study suggests that a strong relationship exists between excessive alcohol use – with or without addiction – and price. As in the case of addiction, there is low responsiveness to price by college males engaged in "binge drinking." On the other, in theory,"by raising prices, higher alcohol taxes could significantly reduce alcohol abuse among youths and young adults, as well as in other segments of the population."[93] Note again, the study does not address the availability on college campuses of illegally acquired alcohol and illegal substitutes to legal alcohol. Refining their view, the authors find that "price rarely has a significant impact on the level of

drinking or drinking participation by young adult female students."[94] Perhaps due to "binge drinking" and the inability to account for free alcohol on college campuses, the authors conclude: "[g]iven the insignificance of price in most of the equations for male college students, these estimates [of marginal effects and price elasticities] suggest that sharp increases in beer taxes, if passed on in the form of higher prices, would have little impact on drinking and binge drinking among male college students."[95] In fact, they conclude that "male college students are virtually unresponsive to price."[96] For reasons that are not further explored, this low PED among these groups for this substance mimic the effects of longer term addiction. Consistent with the idea that alcohol prices are so low on college campuses that marginal price changes do not affect consumption, these authors note that "alcohol availability has a strong positive and significant impact on all measures of drinking and binge drinking..."[96] and that availability is apparently high among the sample groups.

A Twist on Rational Addiction Theory: Muddy Thinking about Treatment, Price Elasticity of Demand and the Underpinnings of Rational Decision Making

One study that offers controversial conclusions, but also refers to strong addiction research in doing so, was presented by Boyam and Kleiman in 1994.[98] While much of this study is unsubstantiated opinion relating to effects of possible drug legalization on crime, its analysis of past data sets is valuable. In many ways, this study represents the mindset of those who have bothered to examine the issue of PED in relationship to drug use. The cornerstone view of these authors and others who have examined PED seems to be that PED is a function of decision making by addicted persons (this much is true), *and that decision making by addicted persons is affected by price, since after a period of time, the addicted person rationally concludes the habit is not maximizing his or her long-run utility.* Thus, addicted persons will choose to stop their addiction, and will apparently be able to do so.

The evidence for such a long-run conversion by addicted persons to nonuse by higher prices and thus a lower PED over time for those addicted (unlike the natural tendency of non-users to avoid initiating use when prices are higher) is plagued with methodological problems.

A few of these problems are mentioned here, and affect this study and those which impute a *higher* PED to addicted persons over time, that is, a greater likelihood of addicted persons to stop use when prices are higher.

Consider the central questions raised – but not answered – by such studies:

- If higher prices affect addicted persons more dramatically than initial purchasers, how available to the addicted population being studied was effective treatment? If highly available, the results would be skewed by factors other than price.

- Similarly, how aggressive were the intervention modalities that were available? If highly aggressive within this study population, then again the impact of prices is masked by aggressive intervention.

- How many of the addicted persons stopped using because they were admitted to emergency room care? Since addiction raises the propensity for emergency room admission and many addictive drugs spur higher emergency room admissions, the effect of price may be altered by changes in the addicted population's access to these drugs.

- The same question may be asked for those addicted persons who stop consuming – and are thus credited with a lower PED – because they have died of their addiction.

- How did the study verify that addicted persons did not merely move geographic locations to gain access the same drugs at lower prices? If the drug prices were higher in a geographic area under study and the numbers of addicted persons went down, one explanation discrediting the notion of higher PED is that addicted persons simply moved in order to consume the same drug at a lower price in a neighboring, but unstudied, drug market.

- How did the study verify that the substitution effect was not in play, such that higher prices of one drug produced a shift in addictions – not a shift downward in drug use – for example, from heroin, to OxyContin or from crack cocaine to methamphetamine? If the substitution effect allowed continued addiction at the same rate, the idea that a reportedly higher PED for one of these drugs is not significant.

- Likewise, why would addiction rates fall faster than initiation rates in any drug market, other than the counterintuitive assertion that addicted persons evaluate long-run use and find it cost ineffective (an unlikely event given the nature of most drug addictions)?

In short, this study and others like it assume that an addicted person will abandon a habit at higher prices, just as higher prices negatively affect initiation rates by nonpurchasers. If this assumption is wrong, which appears at least as likely as not, then studies offering hope to policy makers by linking higher prices to shrinking popu-

lations of addicted persons are misguided, except to the extent that the higher prices reduce initiation, which reduces the pool of future addicted persons. Instead of offering real hope, they only point to the need to intervene early in the cycle of addiction and to avoid making addictive drugs more available at lower prices.

Examining carefully the fallacies that are embodied in the Boyam et al. study is worthwhile. The study holds that, "as far as empirical estimates of the elasticity of demand for illicit drugs goes, only two studies have been widely regarded as methodologically respectable. Both examined the link between heroin prices and crime in the early 1970s, and only indirectly looked at elasticity of demand."[99]

While one might argue that neither study seriously studied the reasons for imputed changes in PED, the follow-on review in Boyam et al. is helpful in understanding the weakness in the field's examination of PED changes. Boyam et al note, for example, that "Brown and Silverman found, for New York City, a positive correlation between price of heroin and rates of different types of crime (such as robbery, burglary and auto theft) which addicted persons would commit to finance drug purchases ... ."[100] Similarly, Boyam et al. note that "Silverman and Spruill performed a similar, but more detailed, analysis ... [which] showed a strong association between heroin prices and crime, especially for property crimes."[101]

Notably, while the authors of both studies fail to point this out, that correlation – if higher than for nonaddicted purchasers – suggests that PED *does slide from high to low*, as addicted persons become less and less able to do without the drug, and thus more and more inclined to crime as a means of seeking money to buy the drug.

Ironically, this study does acknowledge that treatment is key to any reduction in use, presumably at any price, citing a well regarded study by Dupont and Greene, which found that higher prices of heroin in a community enjoying widely available treatment (without segregating addicted purchasers from nonaddicted purchasers) led to a decline in heroin use and lower reported crime.[102] *Perhaps the greatest common sense conclusion elicited is that, "[I]n effect, Dupont and Greene argue that the association between heroin and prices and crime is negative when treatment is available, positive when it is not."*[103]

The weakness in existing research on PED is further illustrated by another observation in this study. Boyam et al assert that: "[S]tudies [like these two] can only measure the elasticity of demand in the short run... . Thus their estimates are likely to understate the effect of price changes once users have the opportunity to discover and habituate themselves to substitute drugs, enter and complete treatment programs and so on."[104]

With no data to support the observation, this is half right, half wrong. The PED will likely fall with increasing addiction, but will rise again as addicted persons substitute

one drug for another or enter treatment and thus – assuming availability of intervention – exit the market for that narcotic.

Unfortunately, the Boyam et al. study glosses over profound problems that lie within their discussion of PED. Meaningful treatment or intervention modalities are often unavailable, making the option of responding to higher prices by entering treatment (even if addicted persons tended toward this option) untenable. Similarly, substitutes exist for some drugs but not for others and the same drug substitutes are not available in all geographic areas. Moreover, the shift from one drug addiction to another, parallel addiction does not alter the population of addicted persons; it simply leads to a broader definition of that population. The PED for one drug may be higher, but the overall PED for addictive drugs in such a geographic area would remain the same.

Accordingly, it is *theoretically* possible for PED to become higher for a given drug in a given addicted population, but not likely. A higher PED could occur only where possible substitutes existed, where they are widely available at the same or lower prices, and where they are chosen by addicted persons over the primary drug. Likewise, it is *theoretically* possible for the PED for a drug to rise – that is, for the decision making of the addicted person to become more responsive to price – if treatment or intervention were universally available, effective and perceived by addicted persons as a viable, desirable, affordable and accessible option. In practice, a higher PED for drugs among addicted persons is unlikely, since many drugs are not perceived as having readily available one-for-one substitutes, and remain widely available (substitutes not being viewed as necessary). Moreover, treatment or effective intervention is often not an available option, nor is it perceived as desirable, affordable, accessible or viable as an alternative to the next purchase - at any price.

Thus, low PED more accurately describes the enduring nature of addiction to widely available and addictive drugs, where there is little likelihood of the addicted person seeking or finding viable treatment or intervention. Missed in these studies is the value of PED in describing the differing behavior of addicted consumers in a given market, not in assuming away the existence of the market by imputing other unlikely behaviors to the addict.

Notably, Boyam et al seem to acknowledge the enduring nature of addiction in discussing the market for any addictive drug. They note, "in the short run, demand is above all a function of consumption among current addicts ... [and] the demand is unlikely to respond quickly to a price increase... [since] not only is it difficult for [addicted persons] to immediately adjust their habits, but they know that most jumps in illicit drug prices reflect temporary interruptions in supply rather than lasting trends."[105] Whether the latter point is true or not (no evidence is presented), the former seems undeniable.

Boyam et al. conclude "the higher price reduces both initiations *and* progressions from initiation or moderate use to heavy use (emphasis added)." In fact, the evidence of reduced *initiation* at higher prices for highly addictive substances is pervasive. The same simply cannot be said for addiction response. The authors acknowledge: "[i]n principle, the addictive nature of drugs may contribute to these effects .... [since] a rational person considering whether or not to take an addictive drug should be more strongly influenced by a change in its price than he would be if the drug were not addictive... ."[106] This much is both supportable and intuitive.

Falling back on rational addiction theory, Boyam et al. suggest that addicted persons will be induced to quit at higher prices "... because the effect of the drug's price on his lifetime budget is greater."[107] Somehow, the authors again assume away cognitive deficit issues associated with addiction by imputing nonaddictive behaviors to those experiencing, among other effects, extreme craving.[108] Thus, their conclusion merely scratches the surface of PED, its real calculation and meaning. In short, this study is also a missed opportunity as it relates to PED.

Economic Analysis of Legalization in the Context of Relative Initiation and Addiction Rates, Price Elasticity of Demand, and Predictable Changes in Consumption

A final study of significance – drawn from many which offer similar reasoning – is the seminal 1990 analysis by Avram, Goldstein, Harold and Kalant entitled "Drug Policy: Striking the Right Balance," published in *Science.* These authors offer valuable insight into addiction, its economic consequences, and several suggested directions for future policy. Chief among their observations are these:

First, addiction is empirically a "compulsive" behavior characterized chiefly by physical dependence and tolerance. Supporting low PED among addicted drug purchasers, they offer:

> People who become addicted usually believe, at the outset, that they will be able to maintain control. After the compulsion takes control, addicted persons persist in using high doses, often by dangerous routes of administration ... [T]here is an urgent need for more research to explain why they doggedly persists in a self-destructive activity despite full knowledge of its consequences.[109]

Second, there is an empirical link between *availability of a drug at low prices* and *initiation rates*. While confirmed by other studies, these authors apply this observation to the notion of legalizing addictive substances and find that the *consumption rates would likely increase considerably.*

In fact, they find that "past experience suggests that the increase in use would be very large ... . [By analogy], the history of alcohol provides some basis for predicting what might be expected from the removal of all drug prohibitions [and] [t]he key question is whether legalization of opiates and cocaine would result in levels of addiction comparable to those seen currently among users of alcohol and tobacco."[110] The authors point out: "[o]piates and cocaine are certainly not *less* addictive than alcohol or nicotine by any criterion [and] although the intravenous route [for administering the drugs] might never become widely popular, smoking (especially of crack) would be the route of choice for the millions."[111] *The study's point is simple: increased availability at lower prices would increase use, which would increase addiction and the disproportionate costs of treating a nation of addicted persons.*[112]

Moreover, the economic trap set by legalizing a highly addictive substance is clearly stated: "[i]f the government were to attempt to prevent large increases in consumption by raising the prices for drugs sold through licit [legal] outlets .... Government would be in the unhappy position of having to choose between raising prices to discourage excessive use, thus allowing the illicit traffic to continue, and lowering prices enough to drive out the illicit trade, thus increasing consumption [citations omitted]."[113] *The depth and onset of the economic trap would vary by narcotic, but the effect would be the same.*

Third, in purely medical terms, there are different levels of addictiveness identified for different types of drugs. While not formally catalogued or charted against one another by the authors, these relative levels of addictiveness are acknowledged by reference to medical science, opening the door to different types of comparative analysis.[114]

Notably, a first step in the direction of establishing comparative "sliding PEDs" for different drugs is arriving at relative levels of addictiveness, or the varying slopes measuring increased use (y-axis) against time (x-axis). While many factors affect the speed at which the average user becomes addicted to any given drug, and some users become addicted more rapidly than others, clinical studies offer useful guidance in establishing the relative rates of (or speed to) addiction.

These rates of (or speeds to) addiction offer a basis for further research on the relative slope of the different sliding PEDs for different drugs. Thus, the price sensitivity of purchasers to each drug could be studied at different times, namely 1) preceding first use, 2) during occasional use and 3) after addiction.

By charting estimated addiction rates (or speed to addiction) for each drug through use over time, we create a likely starting point for confirming the existence of different PEDs for different drugs at different times in the progression toward addiction from first use. This will open the door to a more thorough understanding of the relative prices at which different subgroups within the overall user population consume

addictive drugs, and the degree to which prices are likely to affect – and actually can or cannot affect – overall drug use.

Thus, with respect to cocaine, Avram et al. provide this starting point in comparing its objective addictiveness to other drugs:

> Experiments [with various animal species] have shown that an animal fitted with an indwelling venous cannula, through which it can obtain an injection by pressing a lever, will establish a regular rhythm of lever-pressing if (and only if) the injection contains one of the known addicting drugs [citation omitted]. One measure of the addictiveness of a drug is how hard the animal will work (that is, how many lever-presses it will make) for each injection. Another measure is the extent to which the animal engages in drug self-administration to the exclusion of normal activities... .Yet another measure is the rapidity of relapse after a period of enforced abstinence. *By these criteria, cocaine is the most addictive drug known* (emphasis added).[115]

The authors similarly note that:

> [S]ingle-minded preoccupation of many cocaine, heroin, nicotine, and alcohol addicts with obtaining and using their respective drugs is disturbingly reminiscent of the animal experiment and reflects a major role of direct effects in driving addictive behavior ... .[And] marijuana, which is less dangerous than cocaine or heroin [is] ... by no means harmless.[116]

Referring to THC[117] or marijuana, the authors do not provide any comparative measure of this psychoactive drug's addictiveness, but note:

> It is sometimes argued that as marijuana seems to be the least harmful of the psychoactive drugs ... it could be legalized safely. However, scientific evidence is still insufficient as to the potential magnitude of long-term harm, whereas the acute disturbance of psychomotor behavior is clearly dangerous under certain circumstances. It is not possible to predict with confidence what the result would be of vast expansion of the user pool, especially of heavy users.[118]

In this vein, the most recent information available on the addictive nature and relative health effects of THC and marijuana appeared in 2002 in a study published by the National Institutes of Health, National Institute on Drug Abuse (NIDA). NIDA found that "marijuana [in 2002] is far more potent than the marijuana of 30 years ago ... [and] the drug can produce a range of adverse physical and emotional effects, and – contrary to what many people believe – it can be addictive."

More specifically:

> With high doses of marijuana, the user may suffer toxic psychosis, including hallucinations, delusions, and a loss of the sense of personal identity... . Marijuana has negative effects on memory and learning skills that are persistent but may not be permanent. Other effects of long-term abuse are cumulative and may last indefinitely...[including damage to the immune system]. A serious risk of long-term marijuana use is addiction – compulsive use of the drug... . Withdrawal symptoms and drug craving can make it hard for long-term marijuana users to stop the drug.[119]

While neither the 2002 NIDA study nor the Avram et al study offer a thoroughgoing comparison of addictions, they do offer support for the idea that levels of addiction (rates of or speeds to addiction) can be discussed in comparative terms.

In summary, the existing body of research on PED, as applied to drug use generally and drug addiction in particular, is limited. Most studies mentioning economic issues or making policy recommendations concerning either drug legalization or intervention to stop addiction do not address the issue at all, or refer to PED only in passing.

Where PED is mentioned or alluded to in the literature, it is chiefly to suggest that there is a static relationship between price and consumption of drugs - one that is either viewed as significant or insignificant, but applies across all drugs and with equal weight for both the first time purchaser population and the addicted population.

Where any disaggregation of these two populations is done at all, references are either fleeting or based on the spurious idea that addicted persons will act rationally, that is, in a way that will maximize their long-run utility when assessing when to buy drugs and at what price to stop buying drugs. Despite its prevalence in the literature, this "rational addict" concept is severely undermined by bodies of clinical and empirical evidence suggesting that addicted persons generally do not make decisions based on such long-term calculations and rationality.

Assessing the Popular Economic Argument for Legalization Offered by The Economist

One commonly heard voice on the topic is ***The Economist*** magazine.[120] Ironically, while an unabashed advocate of greater reliance on market forces to reduce drug use, ***The Economist*** has never seriously tackled the issue of a *sliding Price Elasticity of Demand for highly addictive drugs.* In fact, this issue is typically overlooked or dismissed in their regular analyses of drug policy. Thus, in June of 2002, ***The Economist*** argued for downgrading criminal penalties for cannabis, with "penalties for possession becoming nominal," implied support for downgrading of "Ecstasy," and argued for government "heroin prescribing" and "safe injecting houses" under the heading

"treatment" and "reform of Britain's archaic drug laws." The essential premise for this radical shift in policy is that drugs "have never been cheaper" and that "easy availability" now characterizes access to narcotics in Britain.[121]

Missing from their analysis are several critical elements of the economic discussion:

First, while prices may be at an historical low, a policy legalizing drugs of any kind would have to offer the same drugs at competitively low prices or risk quickly becoming irrelevant. In fact, until the government provided drugs in virtually unlimited quantities at the highest purity levels and at no appreciable cost to users, there would continue to be a secondary or black market for purchasers who wished to have more drugs than the government was offering, or a higher purity drug than the government was offering, or at a lower price than the government was offering. In short, given the twin characteristics of addiction - rising drug tolerance and rising dependence - it is hard to imagine the black market disappearing. To the extent that law enforcement resources were employed to address this black market, costs presumably saved by legalization would go uncollected.

Second, almost unmentioned is the enormous cost of either maintaining alive and addicted the population being accommodated in their addiction (particularly where a government assumes the substantial burden of health care) or the cost of effectively treating the addicted population to eliminate addiction, either one of which is likely to exceed the present cost of law enforcement and antidrug abuse education. Moreover, the inconsistency of a government both promoting or facilitating drug abuse and simultaneously seeking to stop drug abuse through expensive treatment is a formula for government outlays on a grand scale.

Third, separate from a persistent secondary market and the costs of treating addiction and addicted persons, any policy reducing penalties and widening availability through government distribution lowers the actual and perceived price associated with using drugs, in effect encouraging consumption. Estimates may range widely, but increases would be material.

As the number of annual users began to rise, so would the number of users becoming addicted. Even low estimates put the initiates-to-addicts ratio at 10 percent. As the pool of addicted users continued to grow, so would the government's commitment to this pool's addiction and medical costs.

Not calculated into this increasing government commitment are higher costs associated with predictably lower workforce productivity, higher domestic abuse, crimes committed under the influence of drugs, accidents, reduced educational achievement and the unquantifiable effects of government sponsorship for drug use.

Perhaps most pointedly, Price Elasticity of Demand plays two unacknowledged roles:

First, government sponsorship and low government prices would almost certainly encourage higher initiation rates, whether directly through government distribution or through recourse to the secondary or black market by those denied access to a government-approved habit. PED would be high for first time purchasers, but lower prices and government sponsorship would encourage increased first use *and* wider acceptance of long-term addiction as "normal" or "government-covered." ***The Economist*** itself notes that "prescribing heroin to hard-core addicts could cost more than 363 million dollars a year,"[122] not including the cost of new addictions and unrelated health care costs growing out of addiction.

The economic inconsistency of ***The Economist***'s position on drug legalization is only made more apparent by reference to their reasoning elsewhere. For example, on the proper approach to health care, ***The Economist*** regularly argues *against* government sponsorship of expensive treatment intervention and for reducing such interventions to lower priority whenever possible. Thus, ***The Economist*** has observed:

> You can't put a price on human life. From this truism springs one of the most harmful delusions of the modern world – that when public money is spent on life-saving medical care, no account should be taken of cost. Given that demand for health care is almost infinite, while budgets are sadly finite, it makes sense to start by spending money on interventions that save lots of lives, cheaply. If good public health is the goal, treatments that save fewer lives at greater cost should receive lower priority.[123]

Presumably, faced with the high cost and low success rate of drug addiction interventions cited by ***The Economist*** in June 2002, this component of their drug reform platform would, in fact, become a "lower priority" for the government.

Similarly, ***The Economist*** has argued persuasively elsewhere against increasing dependence on the government benefits, particularly benefits which might spur widening circles of dependence. Thus, in favoring welfare reform, ***The Economist*** noted the success of America's 1996 reforms, "requiring welfare recipients to work or get job training in exchange for benefits," a law under which "the number of people on welfare has dropped from 14 million in 1994 to 5 million today [August 2002]."[124]

Second, low PED for drugs sought by addicted persons will not change. Accordingly, they will continue to press the government for higher volumes of drugs, individually and as a group, in concert with the rise in tolerance and dependence that attach to all addictions. If the government cannot meet the rising need generated by higher tolerance among a wider population of addicted persons, the addicted population will again turn to the secondary market, and will commit crime to pay for drugs at the

prices demanded in that market. If the government chooses to meet the rising demand generated by higher tolerance among a wider number of users, and thus of addicted persons, the overall financial burden on the government will continue to rise in proportion, mitigated only by a rising number of deaths of addicted persons. As indicated above, this reality flies in the face of past reasoning by ***The Economist*** in other contexts.

In the July 28, 2001 issue of ***The Economist***, the editors advocated broadly for "legalizing drugs," unexpectedly revealing other economic weaknesses. At the outset, they admit that legalizing drugs "would lead to a rise in their use, and therefore to a rise in the number of people dependent upon them."[125]

Also, in direct contradistinction to the article from June 2002 which said drugs "have never been cheaper," the article from less than one year earlier argued "drugs are expensive," adding "a kilo of heroin sells in America for as much as a new Rolls Royce ... ."[126] In fact, the July 2001 article observes: "[r]emove such constraints, make drugs accessible and very much cheaper, and more people will experiment with them ... [and] [a] rise in drug-taking will inevitably mean that more people will become dependent... ."[127]

Somehow, also, the argument is pressed that a shift from free choice in the market to the absence of choice is not significant. Thus, ***The Economist*** acknowledges the argument that "once addicted, they [drug addicted persons] can no longer make rational choices about whether to continue to harm themselves." This is disposed of by noting that both alcohol, which has less abusive potential over a short time frame, and nicotine, about which more is becoming known each year, are legal.[128] Somehow this argument fails to confront the cumulative economic cost associated with these substances,[129] both of which tend to produce less acute harm in a shorter period than heroin, cocaine, methamphetamine, PCP and even – based on some recent studies – high THC content marijuana.[130]

The answer proposed is another conflicting policy, legalization paired with antidrug "health education."[131] This proposal for reducing demand – increasing the resistance to use while widening availability – seems fraught with economic contradictions. Considerable sums have already been spent on demand reduction for both alcohol and cigarettes, yet consumption rates remain high. While prevention is highly effective in reducing demand,[132] this effectiveness has typically required consistency of message and collateral supply reduction efforts. In purely economic terms, and setting aside other externalities, government expenditures on antidrug "health education" together with government-sponsored distribution or legalization of currently illegal drugs are likely to create a counterproductive and wasteful cross-application of government resources.

Finally, ***The Economist***, without reference to the changing nature of Price

Elasticity of Demand among drug consumers – the ebbing of rational choice in consumption patterns based on dependence and tolerance – and the economic trap represented by widening addiction, suggests governments should "proceed gradually" toward making drugs more available, allowing *"for conventions governing sensible drug-taking to develop."* While this analysis might be useful for legalization of nonaddictive substances on other grounds or legalization of mildly addictive substances requiring prolonged use prior to addiction and carrying minimal adverse effects, the economic underpinning is missing for legalization of highly addictive drugs.

Specifically, there is no account taken of the impact that lower cost and wider availability would have on long-run rates and costs of addiction. While acknowledging that the primary economic effect of lower cost and wider availability is that "more people would experiment with them [narcotics]," ***The Economist*** does not then assess what this short-term consequence of legalization would mean, for example by reference to a sliding PED, for addiction.

A Final Comment on Animal Studies and their Application to Price Elasticity of Demand for Drugs among Humans

While somewhat far a field from the day-to-day interactions of the human market, one last set of "economic studies" deserves mention. Selected animal studies have sought to find a progressive PED, equating dollar cost to number of "responses required" or work done to acquire another dosage of the drug. While helpful, these few studies have been short-term sittings in which a nonaddicted animal is subjected to between four and twelve options for acquiring an addictive drug.

While they suggest that higher "price" (measured in work required of the animal) reduces the animal's interest in acquiring more of the drug, they do not represent a meaningful study of addiction or even drug use over a long period (for animals or humans), dollar price changes in a free market, human behavior or the behavior of addicted humans over time. What they do suggest is nevertheless helpful: among certain animals, initiation rates are probably affected by the "cost" (work required for) of initiating consumption.[133] In addition, they may suggest that, after a certain level of dosing, animals may lose the strength required to continue dosing themselves.[134]

Where does that leave us? At no point in the voluminous literature on addiction and economics (and the pseudo-economics) of addictive substance consumption is there mention of a sliding PED for addictive substances. Further, there is no recognition that this dynamic measure is significant as a research and policy tool, first for describing the differences between addicted and non-addicted decision-making over time, and second for reflecting on the evolving, day-in, day-out relationship between price, consumption and addiction for different drugs. Necessarily missing from the literature is any application of this tool - sliding PEDs for different addictive substances – to future policy.

Application of Price Elasticity of Demand to Drugs

Beyond the discussion in the previous section, there are several obvious ways that the "sliding PED" concept[135] and relative ordering of PEDs for various addictive substances over different timeframes could be useful. Several applications for this concept have been discussed previously in this document. Several others are offered in the following section.

Missing Data in Literature on Sliding PED for Addictive Substances

As indicated previously, *there is reason to believe that the notion of sliding PEDs for drugs and the relative ordering of such sliding slopes is both new and useful.*[136] At the very least, it warrants further exploration by both economists and policymakers.

The aim of further study would be to better understand the character of drug use in various purchaser populations and to guide policymakers struggling with conflicting opinions on topics such as drug legalization and widening access to treatment for drug addictions. The primary element of "newness" is application of the language and framework of economic theory relating to PED – free of political, cultural or moral arguments for or against one or another policy options – to the field of addiction and drug policy formulation.

As indicated previously, there are practical reasons for applying the PED concept to drugs and rethinking how other models apply once this is done. Additionally, the absence of prior serious treatment of this concept is a strong basis upon which to advocate for the collection of new data to substantiate or disprove the theoretical premise offered.

One further argument supporting the unique nature of PEDs in the narcotics market, or market for any addictive substance, is that a drug is only replaceable by another drug if the market for the initial product disappears or the initial drug is made less available. The substitution principle is also circumscribed by the relative availability of exact substitutes for the drug being consumed by the addicted population. In other words, *substitution may be highly limited* and increases in price may therefore tend not to affect consumption, but to be reflected in a lower Price Elasticity of Demand for the commodity. When addicted persons need the product, they seek the product at whatever price is asked. If the range of alternatives is narrow and perceived need high, consumption will continue at pre-existing levels despite increases in price.

In economic terms:

> The most important determinant of the value of price elasticity of de-

> mand for a product is the degree to which it has available and acceptable substitutes. Goods which have many substitutes tend to have a relatively elastic demand, since a rise in their prices will induce consumers to switch to the available alternatives, resulting in a greater than proportionate fall in the quantity demanded. Goods which do not have ready substitutes tend to have a relatively inelastic demand. A given price change tends to lead to a less than proportionate change in the quantity demanded because consumers cannot easily buy goods which perform similar functions.[137]

In fact, tying this concept to the addictive nature of cigarettes, Hewitt observes:

> [W]e would not expect the demand for cigarettes to respond very much to a change in price; demand is very inelastic since acceptable substitutes (including abstention) are few.[138]

Note that even this early application of the principle of PED to an addictive substance – a substance arguably less addictive and less immediately destructive on objective data than cocaine, heroin, marijuana, methamphetamine or Ecstasy – assumed that the addiction was present and affected PED.[139]

Missing was any notion of a *sliding PED* for this or any drug, from higher elasticity at the early use stages of the product to lower elasticity after repeat or prolonged use. Also missing was the assessment and comparison of *different sliding PEDs*, or different rates at which the slide from higher to lower PED may occur for different addictive substances.

Sliding PEDs, Drug Legalization and Taxes

Application of this idea has been partially discussed earlier in this study. Still, other implications requiring in-depth examination stem from the relationship between the relatively inelastic demand for drugs by those who are addicted *and the economic effect of hypothetically taxing such a population.*

If narcotics of any kind were legalized, based on the addictive nature of the substances, several economic effects could be predicted from the low PEDs of these substances for addicted consumers.

Relatively lower prices would drive a wider number of initial purchasers to consume these substances.[140] Estimates by economists of note range upwards from eight percent of the population who would be included, on purely economic terms, to initiate use at the lower prices created by legalization.[141]

Even those economic thinkers advocating legalization (removal of all penalties and restrictions on sale of) addictive substances seem to concede that prices would fall

and availability would rise. ***The Economist*** concedes, for example, in July 2001 that legalizing narcotics "would increase the number of people who took them, whatever restrictions were applied," on top of raising "difficult questions about who should distribute them and how." Still, they seem unmoved by the argument that initiation rates would increase. There seems little concern that the PED for any one of countless drugs would rapidly slide from high to low as addiction spread.

In fact, ***The Economist*** accepts that:

> The number of drug users would rise for three reasons. First, the price of legalized drugs would almost certainly be lower – probably much lower – than the present price of illegal ones ...Second, access to legalized drugs would be easier ... And third, the social stigma against the use of drugs – which the law today helps to reinforce – would diminish. Many more people might try drugs if they did not fear imprisonment or scandal.[142]

Initially, this would amount to a new wave of freely made decisions, based on the information available from a variety of sources. The initial decision to purchase by these non-users would weigh costs and benefits and produce, in some percentage of the population, a decision to begin purchasing the drug.

One study recently estimated the price of legalized narcotics at one-twentieth current street prices. If the Price Elasticity of Demand for initiation is high, as this paper argues, one can assume a rate of initiation or first use that is proportional to the drop in price. Even if far less than 20 times the number of first time purchasers responded to legalization by experimentation, the increase in the pool of future addicted persons would be, based on conservative estimates of the percentage of first time purchasers likely to become addicted, enormous.

Put differently, a widely varying estimate of potential new addiction, while speculative, is possible. A drop in price to one-twentieth of the current street price for any given drug could produce an annual increase in teen addiction that ranged wildly *from modestly higher addiction to dramatically higher addiction* given the following conditions:

- if Price Elasticity of Demand for first time purchase of any drug is high (since non-addicted persons respond to higher prices by reducing demand and to lower prices by increasing demand)[143]
- if prices dropped to one-twentieth current street levels under legalization,[144] producing a dramatic increase in new users at lower price
- if today's rate of first purchase is a substantial component of the 40 percent of teens who reported trying marijuana at least once in the year 2000[145] or the 10 percent who admitted to trying Ecstasy[146]
- if the addiction rate for first time use to later addiction is just 10 percent[147]

These estimates – while large – swing widely based on the assumptions surrounding 1) Price Elasticity of Demand for any given drug, 2) actual price change for any given drug if legalized, 3) actual percentage of first time purchasers who choose to purchase a drug after legalization but would not have otherwise chosen to do so (based on factors from lower price to diminished opprobrium),[148] and 4) percentage of first time purchasers that were likely to become addicted to any given drug. *Regardless of which estimates are accepted, the potential for increased addiction is substantial* and would give any policymaker pause.

Moreover, within a short period of time, depending on the addictive nature of each drug legalized and the susceptibility to addiction of the new users, many of the new initiates would slide down the PED spectrum toward a lower and lower PED, rapidly ending in addiction. One predictable result would therefore be an ever-widening number of addicted persons, or individuals trapped at the low PED end of the PED spectrum. Only after the dire consequences of this slowly growing, predictably young, population had become known across the potential new user population would the rise in addiction level off.

The relative economic costs of a sizable influx of new purchasers at a high PED, followed by movement of many to a lower PED and addiction, are illustrated – and likely underestimated – by Avram et al. They note that *empirical evidence* does not support any policy aimed at lowering PED for an addictive substance, since use and addiction climb, together with costs of treatment, which would overshadow any potential economic gain. "It has been argued that legalizing and taxing drugs would provide financial resources for treatment of those who become addicted, but *in Canada in 1984 the total social costs of alcohol were double the revenues generated from alcohol at all levels of government... [and] in the United States in 1983, this ratio exceeded 10 to 1 [citations omitted]."*[149]

In view of the low PED for addictive substances after addiction occurs and highly time-lagged process of recovery (often unsuccessful at initial attempts) from narcotics addiction through treatment, *there are very few indications that the society-wide increase in addicted persons would shrink.* On the contrary, since the PED would be expected to remain low for all such addicted persons, there would be at best only modest shrinkage with widely available, highly effective and wholly appropriate treatment. Moreover, this potential shrinkage in the addicted population would come at great expense, resulting from the high cost of successful narcotics treatment.[150]

Absent widespread and effective treatment regimes, factors that might accelerate a return by the growing pool of addicted persons to economic normalcy, or a position that allowed escape from the low PED for (i.e. dependence upon) addictive drugs, are difficult to identify.

The addicted population would, in a regime that legalized drugs of any kind,

bear the brunt of taxation on these substances. This is the population caught in the relatively inelastic position of needing the drug at any price. In other words, at a minimum, the addicted population already suffering from the physical deterioration associated with these addictions would nevertheless be the population, as a matter of necessity, paying taxes on a product they unavoidably needed. For this population, the PED would be so low that they would be unlikely to be dissuaded from use by even a substantial rise in price created by taxes. In economic terms, "the effect of the tax on a product whose demand curve is ... perfectly inelastic ... is to raise price ... by the full amount of the tax, with no change in quantity bought and sold."[151] Moreover, as indicated earlier, "government would be in the unhappy position of having to choose between raising prices to discourage excessive use, thus allowing the illicit traffic to continue, and lowering prices enough to drive out the illicit trade, thus increasing consumption."[152]

The nature of addiction cannot be overlooked. Just as the PED is low, approaching zero for addiction to many drugs, the notion that a self-sustaining tax base could be established, even with the growth of a larger addicted population, is undercut by several other ironclad economic realities. *Medical care, for example, is costly. Addicted persons who seek to stay alive, either to recover from or simply to sustain their addiction, will prove disproportionately more expensive to keep alive than revenues derived from the predicted increase in taxes from their dependence on government-taxed narcotics.*[153] *On a one-for-one basis, the cost of addiction would quickly outstrip tax revenues generated,* even assuming that any given addicted person could somehow maintain tax payments in the debilitated state of addiction.[154]

The addicted population, while larger, would also tend toward self-limiting stabilization through death. Where the costs of successful treatment, even if available, were unable to be borne by the society or addicted person, many addicted persons would consume a sufficient quantity of narcotics (untreated, albeit in a regime that made self-terminating consumption legal) that they would die. *Theoretically reducing the burden on hospitals and medical care providers, this rise in addiction deaths would substantially reduce the foreseeable increase in tax revenues from an initially expanded population of addicted persons.*

To the extent that addiction cascades any addicted population into other health problems, imposing widening circles of cost on an afflicted society, *the rise in health-related addiction costs may predictably include treatment of collateral ailments, such as psychological impairment, a variety of types of organ damage, HIV and AIDS contraction, as well as a range of predictable drug-related accidents and victimizations which encompass both those addicted and those affected by the addicted population.*

Beyond these economic effects, *the low PED for narcotics would drive addicted persons who craved particular drugs to cheaper alternatives on an emerging black market, since the black market could offer – at a minimum – the same drug for a price*

equal to the drug's production and transshipment costs minus the tax levied by the government. To the extent that any given drug was not offered by the government at high purity and at low cost, the black market would compensate for this economic burden on the narcotics by presenting more pure and cheaper alternatives.

On balance, it is hard to see any sustainable economic advantage, putting aside all other arguments, which might justify drug legalization. In purely economic terms, substantial costs are foreseeable and appear almost inevitable from a decision to legalize narcotics, even on conservative economic estimates of collateral costs and even assuming a sequenced or gradual legalization of various drug regimes.

Other Applications of the Sliding PED Concept to Drug Policy

One obvious application of this sliding PED concept to policy is the economic argument for widely accessible and proactive intervention in order to rescue economically trapped consumers (i.e. addicted purchasers) from an economic position that, in practice, presents few substitutes or alternatives. In short, there is an economic imperative for effective treatment regimes born of the recognition that addicted persons suffer from long-term consumption of a commodity with a very low PED.

Without intervention in a market that no longer allows the laws of supply and demand to properly work, this unique population of consumers (i.e. addicted purchasers) will remain trapped by the low PED of these uniquely addictive commodities (i.e. narcotics) until the adverse health effects of addiction overtake them.

To the extent that the sliding PED concept describes the idea of an economic "black hole," swallowing the market's prime directive of free choice and that directive's resultant elasticity, the economic justification for a compensating economic force – at least as applied to this population – becomes stronger.

From a microeconomic point of view, the addicted person appears to have no exit strategy (other than consumption of a substitute narcotic) from a consumption role that ends in an ever-increasing rate of consumption at either steady or rising prices. Since the addictive commodity is both eroding the addicted consumer's health at a generally rapid rate and this individual is unable to resist consumption even at higher prices, the end state for this consumer is either accelerated death or a substitution of the addiction (or role of addicted consumer) for effective treatment, ending the economic trap of addiction at a low Price Elasticity of Demand. To the extent that the addicted person cannot create the treatment option, this is an option that government should be prepared to create for such trapped consumers.

Also, by inference, there may be a need to prevent others from sliding down the PED spectrum toward addiction, in order to stem the higher costs incurred by addiction. There may also be a need to rapidly and effectively respond to the apparent en-

trapment of addicted purchasers in the economic "black hole" of low PED. For policy purposes, further research is advisable on the question of whether the costs of low PED warrant a significant increase in the measures, however described, that would *prevent* the slide of narcotics consumers down the PED spectrum, while more actively retrieving those from low PED who have already migrated to that nearly inescapable economic position.

Preliminary Conclusions and Recommendations

The conclusions offered are preliminary, since new data sets were not gathered for this literature review and preliminary discussion of the economics surrounding "sliding PEDs for narcotic substances" and "different sliding PEDs for different narcotic substances [i.e. drugs]."

The overarching theme that emerges is the need for real and hard-hitting research and analysis on the economics of several related fields, including the cost-benefit of making effective treatment more widely available in light of the "perfectly inelastic" nature of addiction and the potential impact of policies encouraging lower prices for highly addictive substances, including legalization.

The first theme is associated with lower PED of addictive substances after prolonged use, while the latter is associated with higher PED at the time of initiation for any perceived luxury, including potentially addictive substances. The slide from higher to lower PED is imputed after a thorough review of the relevant literature in both economics and addiction science.

If higher drug prices cannot wean an addicted person off the drug to which he or she is addicted, there will need to be wider promotion of policy alternatives that will reach this population, in tandem with efforts to reduce the inflow of first time, casual or occasional purchasers to the population of addicted purchasers.

Similarly, policies that increase the availability of addictive substances at lower prices, such as proposed drug legalization, cannot find economic support in a predictable and sliding PED for these substances, since they are likely to increase use, increase addiction and disproportionately increase the economic costs to government of addressing the higher addiction rate.

More specifically, this study confirms several economic findings dominant in the literature on economics and addiction. Applying the concept of sliding Price Elasticities of Demand to these findings, several economic policy recommendations emerge. This study does not seek to incorporate or integrate collateral arguments – political, social, moral or emotional – into the recommendations. How these recommendations apply in any particular political, social, moral or emotional context is left to future research and discussion.

Key Findings

- Policies that lower the price of addictive substances tend to increase first time use or initiation rates for these substances.
- Increased use or initiation rates tend to increase addiction rates, based on responsiveness of first time and casual purchasers to lower prices.
- Raising prices of an addictive substance generally appears to lower the rate of first time use or initiation for most addictive substances, although higher prices do not appear to have any substantial impact on consumption by the addicted population.
- Substitution of one addictive substance for another similar substance by the addicted population appears more likely at higher prices and in the event of lower availability.
- Substitution may include accessible, affordable treatment to end the addiction where available, but seems less likely to be chosen where significant effort is required by an addicted population to obtain the treatment.
- Rational or free choice by the addicted population appears to be significantly impaired by a combination of the cognitive deficit produced by using certain addictive substances (i.e. cognitive changes in brain function created by use of the addictive substance) and what is generally described as compulsion, a combination of dependence and growing tolerance to the addictive substance.
- Addictive substances appear to be comparable to one another on several bases, including abusive potency, addictiveness based on time to dependence and rate of tolerance growth, severity of withdrawal symptoms, adverse collateral health, adverse brain function effects and overall physiological and psychological change induced by the addictive substance.
- A price versus time-used continuum appears to exist on which most addictive substances can be placed somewhere relative to one another other.
- This price versus time-used continuum reflects the price sensitivity of purchasers at different times in the use cycle (from first use to addiction) for any given addictive substance relative to any other addictive substance, even if the absolute sensitivity to price by purchasers at a particular time for a particular addictive substance is elusive.
- Most discussants of legalization or government distribution of addictive substances do not take account of predictable long-term growth in the addicted population or the long-term addiction costs associated with this policy choice.

- No discussant of legalization or government distribution of addictive substances takes account of the vast literature supporting a Price Elasticity of Demand for addictive substances that consistently slides from high PED to low PED, albeit at different rates for different addictive substances, unless the addicted population becomes unable to act upon the low PED or substitutes treatment for addiction.

- No discussant of legalization or government distribution of additive substances takes account of the implications associated with a Price Elasticity of Demand that consistently slides, at varying rates for different addictive substances, from high to low for all measured addictive substances, unless the addicted population becomes unable to act upon the low PED or substitutes treatment for addiction.

- Much of the literature on economics and addiction, as well as economics and drug abuse, focuses on a single variable to the exclusion of other variables materially affecting conclusions drawn (i.e. assuming away difficult questions) or is unsubstantiated or opinionated in nature.

- Insufficient economic data and insufficient stratification of purchaser groups exists to confidently measure or estimate the absolute prices (or price ranges) at which different purchaser cohorts (e.g. first time purchasers, occasional, frequent, and addicted purchasers) will choose to purchase or not to purchase different addictive substances.

- Insufficient economic research has been done on the efficacy of generally applying traditional supply and demand principles to the use of addictive substances by different purchaser cohorts (e.g. first time, occasional, frequent and addicted purchasers).

Two primary conclusions grow out of the prevailing economic and addiction literature, the findings in this paper, and the concept of sliding Price Elasticities of Demand for addictive substances:

First, the existence of a high Price Elasticity of Demand for addictive substances at the time when consumers evaluate whether to initiate use of an addictive substance, paired with the high potential costs of addiction to both the individual and society, strongly reinforce policies that have 1) the effect of creating and maintaining high prices in order to deter first use, and 2) the effect of educating potential first time purchasers about the risk of, and costs associated with, possible addiction.

Since the ability to influence consumer decision making is at an apex just prior to the consumer's decision to purchase, or when the potential first time purchaser is deciding whether or not to enter the market, policies targeting price and education at this time – even marginally – are most likely to reduce use and addiction. On the other hand, policies seeking to significantly deter consumption among *addicted per-*

sons through changes in price are not likely to be cost-effective.

Second, the existence of consistently low Price Elasticity of Demand among addicted consumers or frequent purchasers of addictive substances, paired with the adverse economic effects of this consumer group's behavior on individual consumers and society at large, strongly reinforce policies that have 1) the effect of restoring rational consumer decision making, 2) the effect of reducing consumer dependence on and tolerance for these addictive substances, and 3) the effect of restoring this group of consumers to a position of involvement in the economic system based on predictable interplay of supply and demand, namely a position maintained prior to first use of the addictive substance.

While there are points after first purchase and prior to addiction in which price and education may influence consumer behavior, and there are cognitive elements of the decision-making process which may never be restored even after intervention, the most cost-effective way for any society to reduce the cost of addiction is to intervene with effective treatment for one purpose: to end consumption of the addictive substance. Notably, a consumer caught in the economic trap of addiction to a substance with a low Price Elasticity of Demand is not freed by replacing one addictive substance with another. While this policy might be able to reduce the adverse effects of the first addictive substance and replace them with the adverse effects of the second addictive substance, such substitution does not reduce either the costs or the opportunity costs associated with addiction. Moreover, policies that seek to substitute one addiction for another in the name of cost savings tend to be highly expensive and offer no measurable cost-benefit over time, other than accelerating the progress of adverse health effects and death, which reduces the cost to society of health care and addiction maintenance for that consumer.

Additionally, note that substitution of addiction-ending treatment for addiction is only cost-effective when sustained over time. Thus, policies that actively intervene to end addiction must be coupled with policies which educate the formerly addicted consumer to maintain the individual's economic position. While price may then play a modest role in governing the consumer's behavior, other factors beyond price are likely to be equally important, as the consumer may never be as sensitive to price as the individual was prior to first use.

Core Recommendation

In practical and economic terms, the concept of a sliding Price Elasticity of Demand for addictive substances is important. Policymakers can best reduce the costs associated with drug use and addiction in two ways:

- First, by aggressively deterring first time purchases through policies that raise prices and educate potential consumers just prior to market entry, taking advantage of the high Price Elasticity of Demand at that time.

- Second, by aggressively intervening to permanently end addiction through treatment regimes dedicated to stopping (not substituting) consumption of addictive substances, restoring rational economic decision making to consumers affected by addiction, and maintaining this rational economic behavior over time, in response to consistently low Price Elasticity of Demand for different drugs among addicted consumers.

Notes and References

[1]Note, application of these economic principles may appear intuitive for highly addictive substances, such as heroin, cocaine and methamphetamine, but apply with equal force to less addictive substances, including alcohol. See, e.g., Wagenaar, A., and Holder, H., "Changes in Alcohol Consumption Resulting from the Elimination of Retail Wine Monopolies: Results from Five U.S. States," ***Journal of Studies on Alcohol 56*** no. 5 (1995): 566-572; Watts, R., and Rabor, J., "Alcohol Availability and Alcohol-Related Problems in 213 California Cities," ***Alcoholism: Clinical and Experimental Research 7*** (1983):47-58; Gruenewald, P.; Ponicki, W.; and Holder, H., "The Relationship of Outlet Densities to Alcohol Consumption: A Time Series Cross-sectional Analysis," ***Alcoholism: Clinical and Experimental Research 17*** no. 1 (1993): 38-47; Smart, R., "The Impact on Consumption of Selling Wine in Grocery Stores," ***Alcohol and Alcoholism 21*** (1986): 233-236; Rush, B.; Steinberg, M.; and Brook, R., "The Relationships among Alcohol Availability, Alcohol Consumption, and Alcohol-Related Damage in the Province of Ontario and the State of Michigan, 1955-1982," ***Advances in Alcohol and Substance Abuse 5*** no. 4 (1986): 33-45; Wagenaar, A., and Holder, H., "A Change from Public to Private Sales of Wine: Results from Natural Experiments in Iowa and West Virginia," ***Journal of Studies on Alcohol 52*** (1991): 162-173. Studies applying these economic principles to highly addictive substances are set forth elsewhere.

[2]Throughout this document, references to first time use and first time users are intended to implicate first time purchase and purchasers, since first time use itself may not, in fact, involve a purchase.

[3]The basic definition of PED is "the responsiveness of the quantity demanded of a good to its own price" (Pearce, D. W. ((Ed.)) ***The MIT Dictionary of Economics*** ((Cambridge, MA: MIT Press, 1992)): 342). Another economic study offers: " 'Elasticity of demand' is a phrase used to describe the response of consumer demand to changes in price for a particular good. Typically elasticity is expressed as [percentage] decrease in use [divided by percentage] increase in price, so that a 10 [percent] price increase leading to a 20 [percent] decrease in use would be expressed as an elasticity of demand equal to two. Elasticities with a value less than one are referred to as 'inelastic,' elasticities of one are 'unit elastic,' and elasticities with a value of greater than one are 'elastic' or 'highly elastic' depending on their magnitude." LaGrange, J. ***Law, Economics, and Drugs: Problems with Legalization under a Federal System,*** 100 COLUM. L. REV. 505, 509-10, no. 18 (2000).

[4]While detailed further below, existing research tends to suggest either that narcotics consumption is steady at one rate highly responsive to price or at one rate that is highly non-responsive to price. See, e.g., studies arguing that Price Elasticity of Demand is highly inelastic, such as Silverman L. P., and Spruill, "Urban Crime and Price of Heroin," ***Journal of Urban Economics 4*** (1977): 80-103; Roumasset, J., and Hadreas, J., "Addicts, Fences, and the Market for Stolen Goods," ***Public Finance Quarterly 5*** (1977): 247-272; Nisbet T.C., and Vakil, F., "Some Estimates of Price and Expenditure Elasticities among UCLA Students," ***Review of Economics and Statistics 54*** (1972): 474-475, 1972. In two studies, specific points or regions are identified in which different price elasticities of demand exist, namely a high initial rate of sensitivity and a low addicted rate of sensitivity. See White, M. D., and Luksetich, W. A., "Heroin: Price Elasticity and Enforcement Strategies," ***Economic Inquiry 21*** (1983): 557-564; Moore, M., "Supply Reduction Policy and Drug Law Enforcement," in ***Drugs and Crime,*** ed. by Tonry, Michael and Wilson, James Q., Chicago, IL: Univ. of Chicago Press, 1990. Missing is the notion that Price Elasticity of Demand invariably changes or slides over time for any narcotic, that different narcotics have different sliding price elasticities of demand and that this reality has direct implications for public policy.

[5]A significant, if contradictory, body of research has suggested the existence of a "rational addict," giving rise to "rational addiction theory" or "rational addictive behavior." Assumptions underlying this theory, which tends to discourage government intervention, seem dubious. For example, one leading study

notes that "rational addictive behavior" would "emphasize the interdependency of past, current and future consumption of an addictive good" such that addicted persons would calculate future "utility" of present levels of consumption. Putting aside questions surrounding how the addicted person defines "utility" (e.g. does the addicted person seek to maximize future states of euphoria, putting off overdoses until physically beyond euphoria maximization, in some rational way? can we realistically refer to rational, euphoria-maximizing addicted persons?), the notion that rationality attends addiction is questionable at best. Likewise, this study suggests that, "if [addicted] consumers take into account the future costs that they impose upon themselves by abusing alcohol [or narcotics such as marijuana, cocaine or heroin], then the case for higher taxes or other policies to curtail abuse must be based solely on the harm that abusers do to third parties" (Grossman, M.; Chaloupka, F. J.; and Sirtalian, I., "An Empirical Analysis of Alcohol Addiction: Results from the ***Monitoring The Future*** Panels," ***Economic Inquiry 36***, no. 1 ((Jan. 1, 1998)): 13). The questions presented include: Do addicted persons process information that is available about the impact their addiction is having upon them and their future in a rational way? Do well-documented and enduring brain changes that affect addicted persons typically allow for a rational choice by an addict, in the absence of intervention, as to whether an addiction should be continued or terminated? Has economics gone too far when it imposes the assumption of rational decision-making on irrational acts of craving, or the ability of the addicted human mind and body, unaided by others, to choose to continue or arrest addictive behavior? Do decisions by cigarette smokers and alcohol drinkers allow inferences about behaviors of narcotics with greater addictive potency, such as heroin? Finally, is it wrong for public policy to be based, in substantial part, on the "harm that abusers do to third parties"? See also Becker, G. S., and Murphy, K. M., "An Empirical Analysis of Cigarette Addiction," ***American Economic Review*** (June 1994): 396-418; "A Theory of Rational Addiction," ***Journal of Political Economy*** (August 1988): 675-700; and Chaloupka, F. J., "Rational Addictive Behavior and Cigarette Smoking," ***Journal of Political Economy*** (August 1991): 72242.

[6]See references to "rational addict" theory, *supra*, and the laws of supply and demand, *infra*.

[7]Strong statistical data support the argument that higher availability of a highly addictive narcotic leads to a higher rate of use across the studied population, which in turn produces a higher rate of addiction and negative health consequences. One of the more persuasive sets of data is offered by examining heroin availability, purity, use and health consequences in the United States during the 1980s and 1990s. For example: "The rise in average purity recorded by the [Drug Enforcement Agency's Domestic Monitor Program, or DMP] during the 1980s and early 1990s corresponded directly to an increased availability of high-purity Southeast Asian heroin, South American heroin and, to a lesser extent, increases in the purity of Mexican heroin. In 1998, the average purity of South American samples obtained through the DMP was higher than that from any other source, averaging 53.0 percent." At the same time, while highly pure South American heroin accounted for 75 percent of the total net weight of heroin analyzed in the DEA's Heroin Signature Program in 1997, use was climbing. Specifically, by 1997, data from the National Household Survey on Drug Abuse indicated "that heroin use has increased steadily since 1992" and that "the number of Americans who used heroin in the past month increased from 68,000 ... in 1993 to 325,000 ... in 1997." As availability and purity of heroin have increased, triggering increased use and addiction, the rise in negative health effects has also been reliably recorded. For example, over the same period, the annual ***Drug Abuse Warning Network*** (***DAWN***), chronicling emergency room incidents in hospitals across the United States, revealed that "the annual number of heroin-related emergency room (ER) mentions [associated with heroin] increased from 42,000 in 1989 to 76,000 in 1995 – an 80-percent increase ...." (***The National Narcotics Intelligence Consumers Committee Report 1997***, Drug Enforcement Administration, Publication no. DEA-98036 ((November 1998)): 39-40). See also ***Drug Abuse Warning Network: 1995 Preliminary Estimates of Drug-Related Emergency Department Episodes*** (Rockville, MD: Substance Abuse and Mental Health Services Administration, U. S. Department of Health and Human Services, 1996).

[8]*Id.* at 39-40.

[9]See, e.g., the ***Drug Abuse Warning Network: 1995 Preliminary Estimates of Drug-Related Emergency Department Episodes*** (Rockville, MD: Substance Abuse and Mental Health Services Administration, U. S. Department of Health and Human Services, 1996), compiled annually from hospitals across the United States. Likewise, recent research indicates that beyond addictive properties, "[a]cute myocardial infraction is the most commonly reported consequence of cocaine misuse, usually occurring in men who are young, fit and healthy and who have minimal, if any, risk factors for cardiovascular disease" ("Cocaine Use and Cardiovascular Complications," ***Medical Journal of Australia*** ((September 2, 2002)): Clinical Update Section).

[10]For example, widely accepted medical research supports the relationship between use of alcohol in varying degrees, addiction and health impairment, such as severe loss of cognitive function. Accordingly, such research indicates that cognitive ability declines in direct proportion to the severity and duration of alcoholism. See Parsons, O. A., "Neurocognitive Deficits in Alcoholics and Social Drinkers: A Continuum?," ***Alcohol Clinical Experimentation Research 22***, no. 4(1998): 954-961. Note that the concept of a continuum of use leading to addiction comports with the idea of a slowly sliding PED for alcohol, leading toward the straight-line PED, in which the addicted person's decision-making does not change in response to price. See also Beatty, W. W.; Tivis, R.; Stott, H. D.; Nixon, S. J.; and Parsons, O.A., "Neuropsychological Deficits in Sober Alcoholics: Influences of Chronicity and Recent Alcohol Consumption," ***Alcohol Clinical Experimentation Research 24*** no. 2 (2000): 149-154. Such studies also confirm that casual consumers of alcohol who ingest more than 21 drinks per week suffer measurable *long-term* cognitive impairment. Parallel research suggests that the period of time required to detect this damage is *10 years or more*. See Parsons, O. A., and Nixon, S. J., "Cognitive Functioning in Sober Social Drinkers: A Review of Research since 1986," ***Journal of Study of Alcohol 59*** no. 2 (1998): 180-190; see also, e.g., Eckardt, M. J.; File, S. E.; Gessa, G. L.; et al., "Effects of Moderate Alcohol Consumption on the Central Nervous System," ***Alcohol Clinical Experimentation Research 22*** no.5 (1998): 998-1040.

[11]Even minimal repeated exposures to opioid drugs "induces the brain mechanisms of dependence, which leads to daily drug use to avert the unpleasant symptoms of drug withdraw," after which "prolonged use produces more long-lasting changes in the brain that may underlie the compulsive drug-seeking process of decision-making, and related adverse consequences that are the hallmarks of addiction" (Kosten, T. R., M.D., and George, T. P., M.D., "The Neurobiology of Opioid Dependence: Implications for Treatment," ***National Institute on Drug Abuse Science and Practice Perspectives 1***, no. 1 ((July 2002)): 15). See also, note 5 *supra*.

[12]One 1998 study asserts, for example, that based on a comparison of long-run and short-run consumption patters at various prices, "alcohol consumption is somewhat less addictive than cigarette smoking" (Grossman, M.; Chaloupka, F. J.; and Sirtalian, I., "An Empirical Analysis of Alcohol Addiction: Results from the ***Monitoring The Future*** Panels," ***Economic Inquiry 36*** no. 1 ((Jan. 1, 1998)): 12).

[13]In economic terms, product substitution or the "substitution effect" is defined as "the effect on the quantity demanded of a good resulting from a change in price relative to the prices of other goods when the consumer's real income is held constant and other things being equal" (Daithtith, J. ((Ed.)), ***Letts Dictionary of Economics*** ((London, 1983)): 178). Note that substitution theory depends upon a substitute being available.

[14]Grossman, M.; Chaloupka, F. J.; and Sirtalian, I., "An Empirical Analysis of Alcohol Addiction: Results from the ***Monitoring The Future*** Panels," ***Economic Inquiry 36*** no. 1 (Jan. 1, 1998): 12-14.

[15]Indicia of higher and lower addiction rates, based on speed of addiction, severity, observable effects of one time use, occasional and regular use are available which support this proposition. However, additional research would be required to create a generally accepted ordinal (if not absolute) scale of sliding PEDs. Once agreed rates of addiction speed and severity were placed in context, that is measured

against one another, a reliable sliding scale of PEDs for all drugs could be created and used to describe the varying economic costs of different types of addiction. For example, the economic costs to a given society of a widening population of heroin-addicted persons, growing at a rate of "x" persons per "y" population over "z" time period would differ from the economic costs of a widening population of marijuana-addicted persons growing at a rate of "x-n" persons per "y" population over the same "z" time period, assuming a slower migration from first time use to addiction for marijuana users than for high-purity heroin users. If speed of addiction is high in both cases, then the significance of the scale turns on the severity of the addiction and the costs imposed by the addiction severity. In either case, the costs to society would then need to be measured by taking speed of addiction and multiplying it by quantifiable costs of addiction to the specific drug over a set period of time. While difficult, this could be done by access to archival or survey data on "first use to addiction" and by reviewing medical and non-medical costs associated with various addiction types. For example, there are plentiful studies showing the highly addictive nature of heroin, crack-cocaine, cocaine, amphetamines, PCP, high-purity marijuana and nicotine. There are also studies indicating that addiction rates are slower, and Price Elasticity of Demand remains higher over a longer period of time, for alcohol. See, e.g., Babor, T. F.; Mendelson, J. H.; Greenberg, I.; and Kuehnle, J., "Experimental Analysis of the Happy Hour: Effects of Purchase Price on Alcohol Consumption," ***Psychopharmacology 58*** (1978): 35-41. Ultimately, one could create an ordinal scale of addiction speeds and severities that allowed economists to assess and assign a sliding PED – reflecting various speeds to addiction, severities of addiction, and costs of addiction – to each drug studied. While subject to criticism as incomplete, overly narrow, or merely unduly subjective (as the study of human decision-making invariably tends to be), such a sliding PED scale would allow policymakers to understand more clearly the impact of their decisions upon both individuals and society at large. Opening the way to wider addiction or failing to accurately assess the value of intervening to retrieve consumers from costly addictions, in varying degrees, would be a policy failure; if the sliding PED scale assists policymakers in seeing how narcotics addictions function in economic terms, producing such a scale would be worth the exercise. Unfortunately the creation of such a scale, based on a thorough-going review of archival data or drawing new survey data from the addicted population, is beyond the scope of this paper.

[16]Note, reference to a time between first use of any addictive substance and addiction to that same substance is not intended to minimize or discount other factors affecting addiction. For any addictive substance, the number of times used and period over which use occurs are central determinants of long-term addiction. However, the individual nature of addiction should not be underestimated; certain individuals are more susceptible than others to addiction, regardless of the substance under consideration. While the majority of consumers may predictably fall within a time window (from first use to addiction) for a given addictive substance, all consumers are susceptible to genetic or environmental factors that speed or slow the rate at which addiction occurs, and some are highly sensitive to these factors. See, generally, Friel, J., and Friel, L., ***Adult Children: The Secrets of Dysfunctional Families*** (Deerfield, Florida: Health Communications Inc., 1988) ; Jampolsky, L., ***Healing the Addictive Mind*** (Berkeley, California: Celestial Arts, 1991); Gravitz, H. L., and Bowden, J. D., ***Recovery: A Guide for Adult Children of Alcoholics*** (New York: Simon & Schuster, 1985); Nakken, C., ***Reclaim Your Family from Addiction*** (Center City, MN: Hazelden Foundation, 2000). In summary, the proposition advanced is not that genetic and other factors are unimportant, but that addiction to certain substances generally occurs more rapidly.

[17]Driven chiefly by first time users, in 2000, national statistics indicated that "[d]rug related deaths have reached a record level in America, while users have been able to buy cocaine and heroin at some of the lowest prices in decades ..." ("Drug Deaths Reach A Peak As Prices Fall," ***Boston Globe*** ((March 22, 2000))).

[18]Notably, from the mid-1980s through 1992, prices for many narcotics were driven up by coordinated supply interdiction and law enforcement efforts. At the same time, prevention messages for youth were pervasive. Attributable to these two factors were markedly lower initiation rates. "Monthly cocaine use

dropped from nearly 3 million users in 1998 to 1.3 million in 1990 ... [and] [b]etween 1991 and 1992, overall drug abuse dropped from 14.5 million users to 11.4 million." Looked at from another perspective, while prices rose "[o]verall casual drug use by Americans dropped by more than half [between 1977 and 1992] ... [and] [b]etween 1985 and 1992 alone, monthly cocaine use declined by 78 percent." (Walters, J. P., ***Effectiveness of the National Drug Control Strategy and the Status of the Drug War: Hearings before the National Security, International Affairs and Criminal Justice Subcomm. of the Comm. on Gov' t Reform and Oversight***, 104th Cong., 1st Sess. ((1995)): 14, 18 [hereinafter ***Effectiveness Hearings***]). Another expert noted that "crack-cocaine use sharply declined from nearly half a million in 1990 to just over 300,000 two years later in 1992," and "in virtually every category of illegal drug, we saw sharp declines from the mid-1980s through 1992, including "an astonishing 61 percent decline" of regular marijuana users between 1985 and 1992 (Bonner, R. C., ***Effectiveness Hearings***, 104th Cong., 1st Sess. ((1995)): 42-43).

[19]Tetrahydrocannabinol (THC) is the psychoactive component found in marijuana. While marijuana is often paired with other narcotics, such as being soaked in PCP, the purity levels of THC in marijuana itself reportedly ranges up to 40 percent in 2002, a significant increase from one to ten percent levels found in the 1960s.

[20]While an exhaustive medical analysis is beyond the scope of this paper, there is mounting evidence that the shared effects of tobacco and marijuana smoke on the human body – including carbon monoxide, tar and carcinogens – can be separated from the "psychoactive drug effects" of THC in marijuana. Among leading studies on this topic are Gardner, E. L., "Cannabinoid Interaction with Brain," In ***Marihuana and Medicine***. Edited by Nahas, G. G., et al., (New Jersey: Humana Press, 1999). Gardner states: "Although marihuana and other cannabinoids have clear addictive potential, they have been considered by some to be anomalous drugs of abuse, lacking interaction with brain reward substrates. That position is absolutely untenable, in view of more than 10 years of research that shows clearly that marihuana and other cannabinoids have potent augmenting effects on brain reward mechanisms." *Id.* at 189, citing dozens of recent studies on topic. Similarly, a recent study by Hiroi, N., "Dependence, Tolerance and Alteration in Gene Expression," In ***Marihuana and Medicine***. Edited by Nahas, G. G., et al., (New Jersey: Humana Press, 1999) concludes: "Recent studies have included cannabinoids in a class of drugs that act on the mesolimbic dopamine system. [THC], the psychoactive component of cannabinoids, increases dopamine release in the midbrain and in the nucleus accumbens, as do most drugs of abuse." Additionally, THC's psychoactive physical impairments are many, as illustrated by Sutin, K. M., and Nahas, G. G., "Physiological and Pharmacological Interactions of Marihuana (THC) with Drugs and Anesthetics," In ***Marihuana and Medicine***. Edited by Nahas, G. G., et al., (New Jersey: Humana Press, 1999). This 1999 study finds: "THC produces bronchodilation ... causes a dose-dependent tachycardia ... [I]ncreases of blood pressure, but orthostatic hypotension is also observed. Marihuana exacerbates angina pectoris in patients with exercise-inducible myocardial ischemia. [Accounting for] ... psychoactive drug effects, marihuana smoking caused hyperalgesia [and] THC interacts with other drugs: it increases the depressant effects of sedatives and mitigates the effects of stimulants. In addition, severe adverse psychoactive side-effects have been observed when this agent is combined with barbiturates. In combination with opiates or ethanol, THC increases sedation and respiratory depression ...." While none of these studies offers a specific timeline for comparison to other addictive substances, the speed of addiction is suggestive of a rate greater than for tobacco and, for example, less than for opiates.

[21]While there may not be sufficient data to create a definitive "abusive potency" portrait for all narcotics – reflecting the average or mean time between first use and addiction for that drug – there are characteristics which typically attach to addiction for each drug type – and to the speed at which a typical user becomes addicted. Accordingly, one recent study noted: "In contrast to the behavioral effects associated with acute cocaine administration, addictive decision making develops gradually with repeated usage and persists long after the last administration of cocaine. The difference in time courses is important to understanding the mechanisms underlying them. Although the biochemical and cellular mechanisms underlying the acute effects of cocaine have been extensively studied, relatively little effort has

[redacted]

been made to understand the mechanisms underlying chronically induced alterations that appear to be more relevant to drug craving" (Hope, B. T., "Cocaine and a Mechanism for Long-Term Changes in Gene Expression," In ***Marijuana and Medicine***. Edited by Nahas, G. G. et al., ((New Jersey: Humana Press, 1999))). Thus, an incomplete body of data suggests that the rate at which certain drugs are craved after first use differs from other drugs, and that drug potency may be the determinant. Another indication of how to order various rates of addiction is suggested by reference to what certain studies describe as a drug's "abusive potency." Thus, one study has noted that "behavioral activation and its sensitization have been hypothesized to predict a drug's abusive potency ..." (Hiroi, N., "Dependence, Tolerance and Alteration in Gene Expression," In ***Marihuana and Medicine***. Edited by Nahas, G. G., et al., ((New Jersey: Humana Press, 1999)): 207). See also Robinson, T. E., and Berridge, K. C., The Neural Basis of Drug Craving: An Incentive-sensitization Theory of Addiction," ***Brain Research Reviews 18*** (1993): 247-291; Koob, G.F., "Drug Addiction: The Yin and Yang of Hedonic Homeostasis," ***Neuron 16*** (1996): 893-896.

[22] *Id.*

[23] Note that this discussion omits another stark fact surrounding the use of most illegal narcotics: addiction is a state of body or mind that assumes continued life of the addict. In many instances, with highly pure narcotics such as heroin, cocaine, methamphetamine, LSD and PCP-laced marijuana, or highly unpredictable purities such as Ecstasy, life may end on first use with cardiac arrest, accidental overdose or similarly fatal reaction or drug-induced fatal effect, ranging from lung edema to automobile accident. For example, non-injection use of heroin, while not spreading HIV and AIDS, carries a high risk of "untreatable brain damage, with death due to progression of brain damage occurring in about 20 percent of cases" (" `Chasing the Dragon' Heroin Use Can Damage Brain," ***Reuters*** ((November 9, 2001))). This analysis does not discount the frequency of first time use ending in fatality, but focuses instead on addiction as a continuing event.

[24] Substantial medical research supports the "cognitive deficits" model of addiction, documenting a departure from rational decision-making by the addicted person. Specifically: "The cognitive deficits model of drug addiction proposes that individuals who develop addictive disorders have abnormalities in an area of the brain called the prefrontal cortex (PFC). The PFC is important for regulation of judgment, planning, and other executive functions ... [A]s a result, they have reduced ability to use judgment to restrain their impulses and are predisposed to compulsive drug-taking behaviors. Consistent with this model, stimulant drugs such as methamphetamine appear to damage the specific brain circuit – the frontostriatal loop – that carries inhibitory signals from the PFC to the mesolimbic reward system" (Kosten, T. R., M.D., and George, T. P., M.D., "The Neurobiology of Opioid Dependence: Implications for Treatment," ***National Institute on Drug Abuse Science and Practice Perspectives 1***, no. 1 ((July 2002)): 15). In lay terms, "[d]rugs of abuse, such as cocaine, also appear to cause long-term physical alterations in the brain that may make it very difficult for [addicted persons] to merely change their minds about using drugs" (Hope, B. T., ***Cocaine and a Mechanism for Long-Term Changes in Gene Expression, in Marihuana and Medicine*** ((New Jersey: Humana Press, 1999)): 213). Despite conflicts in the literature, a substantial body of research supports the assessment, for example, that "addiction is irrational in the sense that it is not curtailed by the aversive effects of drugs" (Heyman, G. M., "Resolving the Contradictions of Addiction," ***Behavioral and Brain Sciences 19***, no. 4 ((1996)): 573).

[25] *Id.* at 15. For the proposition that rational thought and judgment are replaced by decisions defined by the addiction, see also, e.g. Nakken, C., ***Reclaim Your Family from Addiction*** (Center City, MN: Hazelden Foundation, 2000): 71-90; Jampolsky, L., ***Healing the Addictive Mind*** (Berkeley, California: Celestial Arts, 1991): 23-37. For the proposition that rising prices, while they may affect first time purchases, will not deter the addicted consumers from seeking the drug at any price, see e.g., Heyman, G. M., "Resolving the Contradictions of Addiction," ***Behavioral and Brain Sciences 19***, no. 4 (1996): 573.

[26]More specifically: "Elasticity of demand" is a phrase used to describe the response of consumer demand to changes in price for a particular good. Typically elasticity is expressed as [percentage] decrease in use [divided by percentage] increase in price, so that a 10 [percent] price increase leading to a 20 [percent] decrease in use would be expressed as an elasticity of demand equal to two. Elasticities with a value less than one are referred to as 'inelastic,' elasticities of one are 'unit elastic,' and elasticities with a value of greater than one are 'elastic' or 'highly elastic' depending on their magnitude" (LaGrange, J. ***Law, Economics, and Drugs: Problems with Legalization under a Federal System***, 100 COLUM. L. REV. 505, 509-10, no. 18 ((2000)).

[27]See, e.g., Daithtith, J. (Ed.), ***Letts Dictionary of Economics*** (London, 1983). Another description of PED in this context is: "The responsiveness of the quantity demanded to a change in price in a given market during a given time period, *ceteris paribus*. It is measured by the percentage change in quantity demanded divided by the percentage change in the good's own price ... The value of the PED depends on the availability of close substitutes and their relative prices, the proportion of income spent on the good, habit, alternative uses of the good ...." *Id.* at 140-41

[28]Pearce, D. W. (Ed.), ***The MIT Dictionary of Economics*** (Cambridge. MA: MIT Press, 4th Edition, 1992): 125.

[29]Pearce, D. W. (Ed.), ***The MIT Dictionary of Economics*** (Cambridge. MA: MIT Press, 4th Edition, 1992): 342.

[30]Laidler, D. E. W., ***Introduction to Microeconomics*** (New York: Halsted Press, 2nd Edition, 1981): 26.

[31]While a bit beyond the current discussion, the essential principle can be illustrated in diagram and equation form. In a case such as the two given above, one of which is a relatively low price elasticity (for diapers) and the other relatively high price elasticity (for cereal), both values would be represented by a downward sloping (left to right) demand curve, where the vertical Y axis is price of a unit and the horizontal or X axis is the quantity demanded. As Letts describes the demand curve: "The resulting value [of any relationship in which higher prices generate lower quantity consumed, whether at lower or higher elasticity] will be negative, since when the price rises, the quantity demanded falls (i.e. the demand curve slopes downward from left to right). This method is known as arc elasticity because it measures the responsiveness over the range of prices between [two points]. By reducing the change in price to an infinitesimal amount, the PED at one point on the demand curve can be calculated. Point elasticity demonstrates clearly that PED depends not only on the slope of the demand curve but also on the ratio of the original price and quantity." *Id.* at 140.

[32]"Point elasticity" is the measure of Price Elasticity of Demand where change in the price is extremely small, thus "if change is very small the resulting measure is known as price elasticity of demand." However, if change is very large over the same period of time, this is called "arc elasticity of demand." Accordingly, "if change is significantly large, the measure obtained is one of the responsiveness of demand to this change in price and is generally known as the arc elasticity of demand" (Pearce, D. W. ((Ed.)), ***The MIT Dictionary of Economics*** ((Cambridge. MA: MIT Press, 4th Edition, 1992)): 342).

[33]Salvatore, D., Ph.D., ***Schaum's Outline ofTheory and Problems of Microeconomic Theory*** (New York: McGraw-Hill, 3rd Edition, 1992): 44.

[34]Salvatore, D., Ph.D., ***Schaum's Outline ofTheory and Problems of Microeconomic Theory*** (New York: McGraw-Hill, 3rd Edition, 1992): 44..

[35]*Id.*

[redacted]

[36]*Id.* at 38-44.

[37]*Id.*

[38]Hewitt, G., ***Economics of the Market*** (Great Britain: Fontana/Collins, 1976): 54.

[39]*Id.* at 54.

[40]*Id.* at 54.

[41]*Id.*at 55.

[42]*Id.* at 57.

[43]By way of reference, research describes cocaine as highly addictive, to the point of virtually locking out the choice not to use, even at higher prices. Experimentation under conditions of high PED swiftly turns to perpetual abuse at low PED. As one study explained: "Cocaine-driven humans will relegate all other drives and pleasures to a minor role in their lives ...If we were to design deliberately a chemical that would lock people into perpetual usage, it would probably resemble ... cocaine ..." (Peele, S., and De-Grandpre, R. J., "Cocaine and the Concept of Addiction: Environmental Factors in Drug Compulsions," ***Addiction Research* 6**, no. 3 ((1998)): 235-263, citing Cohen, S., "Reinforcement and Rapid Delivery Systems: Understanding Adverse Consequence of Cocaine," In Kozel, N. J. and Adams, E. H. ((Eds.)), ***Cocaine Use in America: Epidemiologic Clinical Perspectives*** ((Washington, D. C.: Government Printing Office, DHHS Publication no. ADM 85-1414, 1984)): 151-153). The general nature of addiction, driving out choice and locking users into perpetual consumption patterns at any price occurs across drug types. Accordingly, researchers "identify cocaine (and amphetamines, which mimic the effects of cocaine) as addictive in the same sense and as a result of the same changes in 'molecular mechanisms' following chronic drug ingestion as heroin: 'Repeated doses of addictive drugs – opiates, cocaine, and amphetamine – cause drug dependence and, afterward, withdrawal' " (Peele et al., *supra*, citing Hyman, S., "Shaking Out the Cause of Addiction," ***Science 273*** ((1996)): 611-612). See also, e.g., Fishman, M. W., "Behavioral Pharmacology of Cocaine," ***Journal of Clinical Psychiatry 49*** (1988): 7, cited in Peele et al. ("Cocaine appears to be a most potent reinforcer, and the self-administering organism is resistant to any attempts to decrease drug-taking ...Indeed, the drug is so reinforcing that the organism self-administering it becomes totally preoccupied with drug acquisition").

[44]Note that many researchers use the idea of compulsion to describe addictive behavior. See, e.g., Peele et al., *supra.*

[45]Hewitt, G., ***Economics of the Market*** (Great Britain: Fontana/Collins, 1976): 57-58.

[46]Policies that could encourage higher consumption of substances characterized by a PED that rapidly slides from high to low, encouraging addiction by a larger number of first time users, would prove to be highly costly. According to the Office of National Drug Control Policy, for example, 3.6 million chronic drug users disproportionately spread infectious diseases like hepatitis, tuberculosis and HIV. See McCaffrey, B., ***Testimony by ONDCP Director Barry McCaffrey before Senate Comm. on Judiciary***, 105th Cong. (July 23, 1997) [hereinafter ***McCaffrey Testimony***]. Infant mortality is much higher among children born to substance-abusing mothers and hospital charges – not to mention follow-up and lifetime care costs – for infants exposed to illicit drugs are four times greater than those for drug-free infants. See Califano, J. A., Jr., "Substance Abuse and Addiction – The Need to Know," ***American Journal of Public Health 88***, no. 1, (Jan. 1998): 9. Drug-using employees experience higher absenteeism, use more health benefits, require more discipline, and turnover at higher rates than drug-free employees. See McCaffrey testimony *supra.* Likewise, to pick one recent year, child abuse, crime, welfare costs and mortality were all directly affected by addiction. Reputable studies indicate that between 25

and 90 percent of all child maltreatment involves substance abuse. See Barth, R. P., ***Substance Abuse and Child Welfare: Problems and Proposals before the Subcomm. on Human Resources of the House Committee on Ways and Means***, 105th Cong. (Oct. 28, 1997). A majority of arrestees tested positive for drug use at the time of arrest and an estimated 12 million property crimes and two million violent crimes committed each year are drug-related. See, e.g., ***McCaffrey Testimony*** *supra.* In 1995, there were more than half a million drug-related hospital emergency room episodes and this number has continued to rise in a number of categories. See ***Drug Abuse Warning Network: 1995 Preliminary Estimates of Drug-Related Emergency Department Episodes*** (Rockville, MD: Substance Abuse and Mental Health Services Administration, U. S. Department of Health and Human Services, 1996), compiled annually from hospitals across the United States. Finally, 15 to 20 percent of welfare recipients have alcohol and drug addiction problems, and tend to remain on welfare for longer periods of time than those who are free of addiction. See ***Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems among Welfare Recipients*** (Washington, D. C.: Legal Action Center, Sept. 1997). See also Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 (Sept. 28, 1990): 9 ("in Canada in 1984 the total social costs of alcohol were double the revenues generated from alcohol at all levels of government... [and] in the United States in 1983, this ratio exceeded 10 to 1 [citations omitted]").

[47]See also, e.g., for cutting-edge alcohol research and the addictive nature of alcohol paired with discussion of tax policy, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as well as the National Center for Science and the Public Interest, particularly at their web site, www.cspinet.org/booze, with special attention to the "Alcohol Policies Project" and the "research" within that resource. Similarly, recent studies of note include: Wagenaar, A., and Holder, H., "Changes in Alcohol Consumption Resulting from the Elimination of Retail Wine Monopolies: Results from Five U.S. States," ***Journal of Studies in Alcohol 56***, no. 5 (1995): 566-572; Chaloupka, F.J.; Grossman, M.; and Saffer, H., "The Effects of Price on Alcohol Consumption and Alcohol-related Problems," ***Alcohol Research and Health 26***, no. 1 (2002): 22-34; Coate, D., and Grossman, M., "Effects of Alcoholic Beverage Prices and Legal Drinking Ages on Youth Alcohol Use," ***Journal of Law and Economics 43***, no. 1 (1988): 215-238; Cook, P. J., and Moore, M. J., "Environment and Persistence in Youthful Drinking Patterns" In Gruber, J. (Ed.) ***Risky Behavior Among Youth: An Economic Perspective*** (Chicago: University of Chicago Press, 2001): 375-437; Grossman, M., "The Economic Analysis of Addictive Behavior" In Hilton, M. E. and Bloss, G. (Eds.) ***Economics and the Prevention of Alcohol-related Problems*** (Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, NIAAA Research Monograph No. 25, NIH Pub. No. 93-3513, 1993); Manning, W. G.; Blumberg, L.; and Moulton, L. H., "The Demand for Alcohol: The Differential Response to Price," ***Journal of Health Economics 14***, no. 2 (1995): 123-148; Markowitz, S., "The Price of Alcohol, Wife Abuse and Husband Abuse," ***Southern Economic Journal 67***, no. 2 (2000): 279-303; Markowitz, S., and Grossman, M., "Alcohol Regulation and Domestic Violence toward Children," ***Contemporary Economic Policy 16***, no. 3 (1998): 309-320; Markowitz, S., and Grossman, M., "The Effects of Beer Taxes on Physical Child Abuse," ***Journal of Health Economics 19*** no. 2 (2000): 271-282; Mast, B. D.; Benson, B. L.; and Rasmussen, D. W., "Beer Taxation and Alcohol-related Traffic Fatalities," ***Southern Economic Journal 66***, no. 2 (1999): 214-249; Pogue, T. F., and Sgontz, L. G., "Taxing to Control Social Costs: The Case of Alcohol," ***American Economic Review 79***, no. 1 (1989): 235-243; Sloan, F. A.; Reilly, B. A.; and Schenzler, C., "Effects of Prices, Civil and Criminal Sanctions, and Law Enforcement on Alcohol-related Mortality," ***Journal of Studies on Alcohol 55*** (1994): 454-465.

[48]Manski, C. F.; Pepper, J. V.; and Petrie, C. V. (Eds.), ***Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us*** (Washington, D. C.: National Research Council, 2001): 42.

[49]*Id.* at 43.

[50]*Id.* at 43-46.

[51]*Id.* at 44-46.

[52]*Id.* at 46.

[53]See, e.g., Peele et al., *supra* at 9; Vuchinich, R. E., and Tucker, J. A., "Contributions from Behavioral Theories of Choice as a Framework to an Analysis of Alcohol Abuse," ***Journal of Abnormal Psychology 92*** (1988): 408-416; DeGrandpre, R. J. and Bickel, W. K. "Drug Dependence in Consumer Demand" In Green, L. and Kagel, J., ***Advances in Behavioral Economics 3*** (Westport, CT: Greenwood Publishing Group, 1996): 1-35; Carroll, M. E., "The Economic Context of Drug and Non-drug Reinforcers Affects Acquisition and Maintenance of Drug-reinforced Behavior and Withdrawal Effects," ***Drug and Alcohol Dependence 33*** (1993): 201-210; Hursh, S. R., "Behavioral Economics of Drug Self-administration: An Introduction," ***Drug and Alcohol Dependence 33*** (1993): 165-172.

[54]See Peele, et al., citing Fishman, M. W., "Behavioral Pharmacology of Cocaine," ***Journal of Clinical Psychiatry 49*** (1988): 7-10; see also Manski, C. F.; Pepper, J. V.; and Petrie, C. V. (Eds.), ***Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us*** (Washington, D. C.: National Research Council, 2001): 44-46.

[55]Cameron, S. E., "Review of Chaloupka, F. J. et al. (Eds.) ***The Economic Analysis of Substance Use and Abuse,*** ***Eastern Economic Journal 27***, no. 2 (Spring 2001): 245-246. *Cf.* LaGrange, J. ***Law, Economics, and Drugs: Problems with Legalization under a Federal System***, 100 COLUM. L. REV. 505, 509-10, no. 18 (2000): 4-6 (valuable references to PED confirming the value of law enforcement in raising non-dollar price of narcotics for all users). While many non-dollar costs or externalities could be integrated into this analysis, such as the environmental, criminal and social costs which contribute to higher and lower PEDs, this analysis will focus on the rise and fall of the dollar price of narcotics, since this is perceived to be a chief factor affecting the acquisition decisions and reflecting the availability of the narcotic. To some degree, this price is assumed to reflect the inclusion of other externalities, such as the likelihood distributor apprehension by law enforcement.

[56]See, e.g., studies arguing that Price Elasticity of Demand is highly inelastic, such as Silverman, L. P., and Spruill, N. L., "Urban Crime and the Price of Heroin," ***Journal of Urban Economics 4*** (1977): 80-103; Roumasset, J., and Hadreas, J., "Addicts, Fences, and the Market for Stolen Goods," ***Public Finance Quarterly 5*** (1977): 247-272; Nisbet T. C., and Vakil, F., "Some Estimates of Price and Expenditure Elasticities among UCLA Students," ***Review of Economics and Statistics 54*** (1972): 474-475.

[57]See White, M. D., and Luksetich, W. A., "Heroin: Price Elasticity and Enforcement Strategies," ***Economic Inquiry 21*** (1983): 557-564; Moore, M., "Supply Reduction Policy and Drug Law Enforcement," In Tonry, M., and Wilson, J. Q. (Eds.) ***Drugs and Crime*** (Chicago, IL: University of Chicago Press, 1990).

[58]Cameron, S. E., "Review of Chaloupka, F. J. et al. (Eds.) ***The Economic Analysis of Substance Use and Abuse,*** ***Eastern Economic Journal 27***, no. 2 (Spring 2001): 245-246.

[59]*Id.*

[60]For the proposition that rational thought and judgment are replaced by decisions defined by the addiction, see, e.g. Nakken, C., ***Reclaim Your Family from Addiction*** (Center City, MN: Hazelden Foundation, 2000): 71-90; Jampolsky, L., ***Healing the Addictive Mind*** (Berkeley, California: Celestial Arts, 1991): 23-37.

[61]Kosten, T. R., M.D., and George, T. P., M.D., "The Neurobiology of Opioid Dependence: Implications for Treatment," ***National Institute on Drug Abuse Science and Practice Perspectives 1***, no. 1 (July 2002): 15.

[62]Hope, B. T., "Cocaine and a Mechanism for Long-Term Changes in Gene Expression," In ***Marihuana and Medicine***. Edited by Nahas, G. G., et al., (New Jersey: Humana Press, 1999): 213.

[63]Heyman, G. M., "Resolving the Contradictions of Addiction," ***Behavioral and Brain Sciences 19***, no. 4 (1996): 573.

[64]Cameron, S. E., "Review of Chaloupka, F. J. et al. (Eds.) ***The Economic Analysis of Substance Use and Abuse***," ***Eastern Economic Journal 27***, no. 2 (Spring 2001): 245-246.

[65]Cameron, S. E., "Review of Chaloupka, F. J. et al. (Eds.) ***The Economic Analysis of Substance Use and Abuse***," ***Eastern Economic Journal 27***, no. 2 (Spring 2001): 245-246.

[66]Grossman, M.; Chaloupka, F. J.; and Sirtalian, I., "An Empirical Analysis of Alcohol Addiction: Results from the ***Monitoring The Future*** Panels," ***Economic Inquiry 36***, no. 1 (Jan. 1, 1998).

[67]Commonly recognized elasticities are the Price Elasticity of Demand, cross elasticity of demand, elasticity of supply, point elasticity, arc elasticity, income elasticity, elasticity of technical substitution, and often the relation of elasticity to total expenditures. See, e.g., Pearce, D. W. (Ed.), ***The MIT Dictionary of Economics*** (Cambridge. MA: MIT Press, 4th Edition, 1992); Salvatore, D., Ph.D., ***Schaum's Outline ofTheory and Problems of Microeconomic Theory*** (New York: McGraw-Hill, 3rd Edition, 1992); Daithtith, J. (Ed.), ***Letts Dictionary of Economics*** (London, 1983); Laidler, D. E. W., ***Introduction to Microeconomics*** (New York: Halsted Press, 2nd Edition, 1981); Sowell, T., ***Basic Economics: A Citizen's Guide to the Economy*** (New York: Basic Books, 2000); Slavin, S., ***Economics: A Self-Teaching Guide*** (New York: Wiley, 1999).

[68]Grossman, M.; Chaloupka, F. J.; and Sirtalian, I., "An Empirical Analysis of Alcohol Addiction: Results from the ***Monitoring The Future*** Panels," ***Economic Inquiry 36***, no. 1 (Jan. 1, 1998): 11-12.

[69]Keeler, T. E.; Hu, T.; Manning, W. G.; and Sung, H. Y., "State Tobacco Taxation, Education and Smoking: Controlling for the Effects of Omitted Variables," ***National Tax Journal 54*** (March 1, 2001).

[70]*Id.* at 1.

[71]*Id.* at 4. In fact, the study acknowledges that "working with individual data (rather than state averages) would represent a superior way of analyzing the relationship between education and smoking, and definitive results await disaggregated studies on this topic." *Id.* at 9. The same may be said for the conclusions drawn concerning PEDs and the overall state population.

[72]See, e.g., LaGrange, J. ***Law, Economics, and Drugs: Problems with Legalization under a Federal System***, 100 COLUM. L. REV. 505, no. 18 (2000): 510.

[73]Saffer, H.; Chaloupka, F. J.; and Dhaval, D., "State Drug Control Spending and Illicit Drug Participation," ***Contemporary Economic Policy 19***, iss. 2 (April 1, 2001).

[74]The laws of supply and demand are almost intuitive, when applied to non-addictive substances. Thus, Thomas Sowell has written: "There is perhaps no more basic or more obvious principle of economics than the fact that people tend to buy more at a lower price and less at a higher price. By the same token, people who produce goods or supply services tend to supply more at a higher price and less at a lower price .... The fact that people demand more at a lower price and less at a higher price may be easy to understand, but is also easy to forget. Seldom, if ever, is there a fixed quantity demanded" (Sowell, T., ***Basic Economics: A Citizen's Guide to the Economy*** ((New York: Basic Books, 2000)):16). Note that Sowell does not address, and the laws of supply and demand are not fitted to explain, the case in which an addicted person or addicted population sees the quantity needed or

demanded as fixed. More formally, the demand function is "an equation expressing the mathematical relationship between the quantity demanded of a good or service and another variable (usually price), in a given market and specified time period" (Daithtith, J. ((Ed.)), ***Letts Dictionary of Economics*** ((London, 1983)): 40). Typically, the demand curve is a line on a graph showing the quantity consumers will buy (x axis) plotted against the changes in price (y-axis), a line that is downward-sloping from left to right. Meanwhile, supply is the quantity produced for purchase at any given price. Thus, the supply curve is a different curve, upward-sloping from left to right, where quantity is on the x-axis and price is on the y-axis. The supply curve tends to show that more goods are offered for sale at higher prices, since there is a greater incentive to sell at higher prices, albeit with diminishing returns. *Id.* at 178-79.

[75]Saffer, H.; Chaloupka, F. J.; and Dhaval, D., "State Drug Control Spending and Illicit Drug Participation," ***Contemporary Economic Policy 19***, iss. 2 (April 1, 2001): 2.

[76]*Id.*

[77]*Id.* at 5.

[78]See, e.g., "The Case for Legalization," ***The Economist*** (July 28, 2001): 11.

[79]*Id.* at 5-6.

[80]*Id.* at 10.

[81]See, e.g., "The Case for Legalization," ***The Economist*** (July 28, 2001): 11.

[82]Johnson, R. A., and Gerstein, D. R., "Initiation of Use of Alcohol, Cigarettes, Marijuana, Cocaine, and Other Substances in U.S. Birth Cohorts since 1919," ***American Journal of Public Health 88***, iss. 1, (Jan. 1, 1998).

[83]*Id.* at 10.

[84]*Id.*

[85]*Id.*

[86]See, e.g., LaGrange, J. ***Law, Economics, and Drugs: Problems with Legalization under a Federal System,*** 100 COLUM. L. REV. 505, no. 18 (2000); Licari, M. J., and Meier, K. J., "Regulatory Policy when Behavior is Addictive: Smoking, Cigarette Taxes and Bootlegging," ***Political Research Quarterly***, (March 1, 1997).

[87]Licari, M. J., and Meier, K. J., "Regulatory Policy When Behavior is Addictive: Smoking, Cigarette Taxes and Bootlegging," ***Political Research Quarterly 50*** (March 1, 1997).

[88]Note direct reference to reliance upon "a simple theory derived from the economics of supply and demand ... ." *Id.* at 1.

[89]*Id.* at 5.

[90]In this particular study, the lagged dependent variable is added to the analysis as follows: "Focusing on the lagged model, a one-cent-per-pack real increase in taxes, is associated with a reduction in cigarette consumption of .813 packs per person for state taxes and .824 packs per person for federal taxes. With a lagged dependent variable, this is the impact for the first year increase. The impact for the second year is equal to these slopes times the regression coefficient for the lagged dependent variable; for

state taxes this is .813 x [times] .972, or about .79 packs per capita. Impacts for subsequent years can be calculated in a similar manner, producing a geometrically distributive lag [citations omitted]. Initial reductions in smoking continue into the future at a gradually declining rate." *Id.* at 10-11. While this presents a neatly distributed set of data, it may not comport with the average real speed of addiction or the relative speed at which addicted persons decide to ignore price in order to acquire a narcotic. Moreover, the more intense an addict's need to consume a given drug – that is, the higher the abusive potency of the drug -- the steeper the likely decline toward non-responsiveness to price. Thus, if heroin is more addictive in a shorter period of time than nicotine, then use of a lagged dependent variable will be of less value as a descriptor of real decision making by addicted persons over time.

[91]*Id.* at 8. This observation scratches the surface of the sliding PED, since the reference to "stickiness" of consumption in response to price is the result of the sliding PED for addictive nicotine. However, like other studies in the addiction and economics field, this study discounts the importance of such "stickiness" as an indicator of declining responsiveness that swiftly approaches zero. Instead, this study seeks to compensate for the perceived reduction in responsiveness to price among addicted purchasers by suggesting that addicted purchasers, like all drug purchasers, simply become marginally less responsive over time to incremental price changes. In fact, a more likely description of the nature of addiction, especially for drugs with a high abusive potency, is that addicted persons become *significantly* less responsive *rapidly*, even in the face of *major* price changes.

[92]Chaloupka, F. J., and Wechsler, H., "Binge Drinking in College: The Impact of Price, Availability and Alcohol Control Policies," ***Contemporary Economic Policy*** (October 1, 1996).

[93]*Id.* at 3. See also, e.g., Cook, P. J., and Moore, M. J., "Drinking and Schooling," ***Journal of Health Economics***, (Dec. 1993): 411-429; Kenkel, D. S., and Ribar, D. C., "Alcohol Consumption and Young Adults' Socioeconomic Status," ***Brookings Papers on Economic Activity: Microeconomics*** (Washington, D.C.: The Brookings Institution, 1994).

[94]Chaloupka, F. J. and Wechsler, H., "Binge Drinking in College: The Impact of Price, Availability and Alcohol Control Policies," ***Contemporary Economic Policy 14***, no. 4 (October 1, 1996): 9.

[95]*Id.* at 10.

[96]*Id.* at 12.

[97]*Id.* at 11.

[98]Boyam, D., and Kleiman, M. A. R., "Drug Enforcement Challenge" In Wilson J. Q. et al. (Eds.) ***Crime and Public Policy*** (San Francisco: Institute for Contemporary Studies, 1994).

[99]*Id.* at 21, citing to Brown, G. F., and Silverman, L. P., "The Retail Price of Heroin: Estimation and Applications," ***Journal of the American Statistical Association 69*** (1974): 595-606; Silverman, L. P., and Spruill, N. L., "Urban Crime and the Price of Heroin," ***Journal of Urban Economics 4*** (1977): 80-103.

[100]Boyam, D., and Kleiman, M. A. R., "Drug Enforcement Challenge" In Wilson J. Q. et al. (Eds.) ***Crime and Public Policy*** (San Francisco: Institute for Contemporary Studies, 1994).

[101]*Id.* at 22.

[102]Boyam et al., *supra,* at 22, citing to Dupont, R. L., and Greene, M. H., "The Dynamics of a Heroin Addiction Epidemic," ***Science 181*** (1973): 716-722.

[redacted]

[103]*Id.* at 22.

[104]*Id.*

[105]*Id.*

[106]*Id.* at 23.

[107]*Id.*

[108]If not generally accepted, the notion of extreme craving for the addictive substance, together with a growing tolerance, is implicit in the commonly used definitions of addiction. "The behavioral and psychological markers of addiction were codified as pathologic withdrawal and craving in a deterministic model that replicated the alcoholism-as-disease notion of drug-induced loss of control" (Peele, S., and DeGrandpre, R. J., "Cocaine and the Concept of Addiction: Environmental Factors in Drug Compulsions," ***Addiction Research*** **6**, no. 3 ((1998)): 1). See also Levine, H. G. "The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America," ***Journal of Studies on Alcohol 39*** (1978): 143-174; Peele, S., "Addiction as a Cultural Concept," ***Annals of the New York Academy of Sciences 602*** (1990): 205-220. "The addicting drugs have two special characteristics with policy implications. First, repeated long-term administration produces a state of physical dependence, so that neurochemical brain function is disturbed (withdrawal syndrome) if the drug is suddenly discontinued .... Dependence accounts, in part, for the compulsion to continue use of an addicting drug ....The second special characteristic, tolerance, is typically associated with the development of physical dependence, [and] is manifested by a tendency to escalate dosage because the same dose is no longer as effective as it was before" (Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 ((Sept. 28, 1990)): 4).

[109]Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 (Sept. 28, 1990): 4.

[110]*Id.* at 9.

[111]*Id.*

[112]The study states: "There is not reason to doubt that the increased costs to society would rival those now attributable to alcohol. In that case, the economic savings that might be achieved, even if it were possible to eliminate all the costs of drug law enforcement, might well be offset by the traditional costs resulting from the consequences of increased drug use." *Id.*

[113]*Id.* at 9.

[114]One reservation: This model may not fully capture the powerful effect of poly-drug addiction or "potentiation" between varying drugs of addiction, despite offering a graduated assessment of varying types of addiction related to differing drugs or differing abusive potencies, in turn associated with particular types of drugs.

[115]*Id.* at 5.

[116]*Id.* at 5, 11.

[117]THC is the psychoactive component found in marijuana, and the acronym for tetrahydrocannabinol. While marijuana is often paired with other narcotics, such as being soaked in PCP, the purity levels of THC in marijuana itself reportedly ranges up to 40 percent in 2002, a significant increase from one to

ten percent levels found in the 1960s.

[118] *Id.* at 13. Note that recent research has added a number of medical factors to the use of marijuana suggesting significant long-run health and addiction concerns. See ***Research Report: Marijuana Abuse*** (National Institute for Drug Abuse, National Institutes of Health, No. PHD940, 2002).

[119] "New Research Report Presents Marijuana Facts," ***NIDA Notes: National Institute on Drug Abuse 17***, no. 3 (2002): 15, citing ***Research Report: Marijuana Abuse*** (National Institute for Drug Abuse, National Institutes of Health, No. PHD940, 2002).

[120] See, e.g., "Drugs: It's All in the Price," ***The Economist*** (June 8, 2002): 52-53; "The Case for Legalization," ***The Economist*** (July 28, 2001): 11.

[121] "Drugs: It's All in the Price," ***The Economist*** (June 8, 2002): 52-53.

[122] *Id.* at 53.

[123] "Cheap Cures," ***The Economist*** (August 17, 2002): 13.

[124] "The Young and the Rested," ***The Economist*** (August 24, 2002): 24.

[125] "The Case for Legalization," ***The Economist*** (July 28, 2001): 11.

[126] *Id.*

[127] *Id.*

[128] *Id.*

[129] For example, in Canada in 1984 the total social costs of alcohol were double the revenues generated from alcohol at all levels of government... [and] in the United States in 1983, this ratio exceeded 10 to 1 [citations omitted]. See Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 (Sept. 28, 1990): 9; "Statistics on Alcohol and Drug Use in Canada and Other Countries," In Adrian, M.; Jull, P.; and Williams, R. (Compiled) ***Statistics on Alcohol Use, Data Available by 1988, Volume I*** (Toronto: Addiction Research Foundation, 1989); ***Alcohol and Health, Sixth Special Report to the U.S. Congress*** (Rockville, MD: U.S. Department of Health and Human Services, NIDA, 1987).

[130] Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 (Sept. 28, 1990): 9, noting: "It is sometimes argued that as marijuana seems to be the least harmful of the psychoactive drugs ... it could be legalized safely. However, scientific evidence is still insufficient as to the potential magnitude of long-term harm, whereas the acute disturbance of psychomotor behavior is clearly dangerous under certain circumstances. It is not possible to predict with confidence what the result would be of vast expansion of the user pool, especially of heavy users." Similarly, one recent study notes: "A serious risk of long-term marijuana use is addiction – compulsive use of the drug ... Withdrawal symptoms and drug craving can make it hard for long-term marijuana users to stop the drug" (***Research Report: Marijuana Abuse*** ((National Institute for Drug Abuse, National Institutes of Health, No. PHD940, 2002))).

[131] "The Case for Legalization," ***The Economist*** (July 28, 2001): 11.

[132] Recent indicators are, for example, that media-based education and prevention programs, combined with current law enforcement regimes, reduce demand for targeted addictive substances. Thus, "[s]

tatistically significant changes in marijuana-related attitudes also occurred between 1998 and 2000 [in the United States], and coincide with the launch of a multi-million dollar, anti-drug media campaign, much of which has targeted teens with messages about marijuana" ("Teen Drug Use Down and Holding," ***The News: Newsletter of the Partnership for a Drug Free America*** ((Winter 2001)): 2). Similarly, then-President and CEO of the Partnership for a Drug Free America noted in 2001: "With so much deemed ineffective in the fight against drugs, here is a program that's working ... [and] may prove to be the most cost-effective drug-prevention program ever funded by the government." Notably, such messages are both consistent and unhampered by a government policy actually promoting distribution of the drugs toward which the prevention program is directed. *Id.*

[133]See, e.g., Peele et al. at 9-11; Goldberg, S. R., and Kelleher, R. T., "Behavior Controlled by Scheduled Injections of Cocaine in Squirrel and Rhesus Monkeys," ***Journal of Experimental Analysis of Behavior 25*** (1973): 93-104; Harrigan, S. E. and Downs, D. A., "Self-Administration of Heroin, Acetylnethadol, Morphine and Methadone in Rhesus Monkeys," ***Life Sciences 22*** (1978): 619-624; Peden, B. F., and Timberlake, W., "Effects of Reward Magnitude on Key Pecking and Eating by Pigeons in a Closed Economy," ***The Psychological Record 34*** (1984): 397-415.

[134]See Peele et al., at 11. While Peele et al. seek to divine added meaning from these limited animal studies, suggesting that "as unit price increases, response rate first increases, reaches a maximum, and then decreases" – and that these drugs are thus *less* addictive over time – more likely is the conclusion that these animals simply dosed themselves to a point where future dosing required more "work" than they were willing to put forward. Unclear, too, is how quickly after experimentation the animals (squirrels and monkeys) died. Notably, also, there is considerable research suggesting that animals will become more addicted over time and are "resistant to attempts to decrease drug taking" (Fishman, M.W., "Behavioral Pharmacology of Cocaine," ***Journal of Clinical Psychiatry 49*** ((1988)): 7-10. Errors inherent in drawing any significant conclusions from these highly limited animal studies have not prevented those who subscribe to the "harm reduction model" from citing them to support of the notion that addiction is self-limiting and that humans can "quit without treatment" (Peele et al., citing to Fiore, M. C.; Novotny, T. E.; Pierce, J. P.; Giovino, G. A.; Hatziandreu, E. J.; Newcomb, P. A.; Surawicz, T. S.; and Davis, R. M., "Methods Used to Quit Smoking in the United States," ***Journal of the American Medical Association 263*** ((1990)): 2760-2765). A substantial body of counter-veiling economic and addiction research suggests that this is a spurious conclusion when applied to human decision-making under the influence of addictive drugs.

[135]Both in economic literature and in addiction literature, there appears to be no prior reference to the idea of a "sliding PED" by any name, or application of a "sliding PED" to consumption of differing types of addictive substances, including narcotics. Nor is there recognition that different addictive substances carry different sliding PEDs, describing the different characteristics of their user populations and producing different policy implications. Passing reference is made in both addiction literature and economic literature to the general PED concept in the context of addiction. These studies are discussed above. There is also casual awareness that a non-constant PED might apply to consumption of addictive substances or narcotics. However, this casual understanding is nowhere set forth as the basis for further study of the "sliding PED" concept and its application to various addictive substances.

[136]As indicated in the foregoing note, no formal recognition has been made of the "sliding PED," particularly as applied to consumption of addictive substances and the impact that this concept on policy. The notion of differing PEDs, as well as the relative "stickiness" or "non-responsiveness" of different consumer goods to price in different populations is well understood, but application of a "sliding PED" to decision-making by consumers initially not addicted and thereafter becoming addicted, has not been explored. By metaphor, one might argue that the dots exist on the paper, but have yet to be connected, or the stars exist in the night sky, but the constellation they comprise has not yet been fully recognized. Expressed differently, researchers have archived substantial knowledge on the topics of addiction, the general utility and workings of Price Elasticity of Demand, of addicted decision-making, of con-

sumption by addicted persons and non-responsiveness to price change, of initiation rates for non-users and their responsiveness to price, and of the relationship between availability, price and general use. These are the various species of data which have been observed and chronicled over time. Missing has been a unifying way to explain that the PED for narcotics does not remain constant for any given addicted person or for a given user population migrating toward addiction to a particular drug. Nor has there been an easy way to express or describe the fact that users consume at different rates of responsiveness to price based on the type of drug being consumed. The notion of "sliding PEDs" specific to particular drugs, and generally applicable to narcotics or addictive substances, is a unifying concept of sorts, much as Darwin invented nothing new, but merely explained what he and many others before him had already seen clearly. In this case, the idea of sliding PEDs for addictive substances generally, and for various narcotics in particular, provides a better or different description – in the language of economics – for facts generally well understood by the prevailing literature and respective fields.

[137]Hewitt at 59.

[138]*Id* at 60.

[139]See also Boyam et al., *supra,* at 22, citing to Dupont, R. L., and Greene, M. H., "The Dynamics of a Heroin Addiction Epidemic," ***Science 181*** (1973): 22 ("in the short run, demand is above all a function of consumption among current addicts ... [and] the demand is unlikely to respond quickly to a price increase ..."); Licari, M. J., and Meier, K. J., "Regulatory Policy When Behavior is Addictive: Smoking, Cigarette Taxes and Bootlegging," ***Political Research Quarterly 50*** (March 1, 1997): 5 ("Since the nicotine in tobacco is highly addictive, current consumption levels are highly dependent on prior consumption levels [citation omitted], and the responsiveness of demand to price (or tax) increases and policy changes should demonstrate some stickiness").

[140]See, e.g., Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 (Sept. 28, 1990):4, 9 (legalizing could affect "millions" of new users).

[141]See Grossman, M., and Chaloupka, F., "The Demand for Cocaine by Young Adults: A Rational Addiction Approach," ***Journal of Health Economics 17***, no. 4 (1998): 427-474; see also Chaloupka, F. J.; Grossman, M.; and Tauras, J. A., "The Demand for Cocaine and Marijuana by Youth," ***Economic Analysis of Substance Use and Abuse*** (University of Chicago, 1999); Saffer, H.; Chaloupka, F. J.; and Dhaval, D., "State Drug Control Spending and Illicit Drug Participation," ***Contemporary Economic Policy 19***, iss. 2 (April 1, 2001): 5.

[142]"Set It Free," ***The Economist*** (July 28, 2001): 15-16.

[143]Regardless of actual numbers, even ***The Economist*** estimates that lower price would dramatically increase the number of users. See "Set It Free," ***The Economist***, (July 28, 2001): 15.

[144]"Set It Free," ***The Economist***, (July 28, 2001): 15, citing to "Mark Kleinman, a drug policy expert at the University of California in Los Angeles."

[145]***The News: Newsletter of the Partnership for a Drug Free America*** (Winter 2001): 2, citing to the 2000 Partnership Attitude Tracking Study (PATS).

[146]*Id.* at 2.

[147]Many estimates are higher than 10 percent based on the abusive potency of the narcotic being legalized.

[148]One economic study suggested: "Removal of the legal restrictions would risk conveying the message

that drug use is not really as harmful as the students had come to believe and thus would weaken an important influence tending to keep consumption levels low" (Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 ((Sept. 28, 1990)): 9).

[149]Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 (Sept. 28, 1990): 9.

[150]*Id.* at 9. See also, e.g., "Statistics on Alcohol and Drug Use in Canada and Other Countries," In Adrian, M.; Jull, P.; and Williams, R. (Compiled) ***Statistics on Alcohol Use, Data Available by 1988, Volume I*** (Toronto: Addiction Research Foundation, 1989); ***Alcohol and Health, Sixth Special Report to the U.S. Congress*** (Rockville, MD: U.S. Department of Health and Human Services, NIDA, 1987).

[151]Hewitt, G., ***Economics of the Market*** (Great Britain: Fontana/Collins, 1976): 62-63.

[152]Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 (Sept. 28, 1990): 9.

[153]See reference notes 90, 91 and the accompanying text.

[154]In addition to previously described costs, note that – by analogy – "the role of alcohol and other drugs in highway accidents is well documented ...." (Goldstein, A., and Kalant, H., "Drug Policy: Striking the Right Balance," ***Science 249***, no. 4976 ((Sept. 28, 1990)): 13); see also Moskowitz, H., and Robinson, C. D., ***Effects of Low Doses of Ethanol on Driving-Related Skills: A Review of the Evidence*** (Washington, D. C.: Department of Commerce, National Technical Information Service, 1988); Yesavage, J. A.; Leirer, V. O.; Denari, M.; and Hollister, L. E., "Carryover Effects of Marijuana Intoxication on Aircraft Pilot Performance," ***American Journal of Psychiatry 142*** (1985): 1325-1329. (referring to same effects with marijuana); Kalant, O. J., ***The Amphetamines: Toxicity and Addiction*** (Toronto: University of Toronto Press, 1973); Johnson, E. D., "Thompson Family Feels the Impact of Marijuana," ***Las Vegas Sun*** (Oct. 28, 2002) (example death from driver under influence of marijuana).

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ARTICLE: BACK TO THE FUTURE: THE COLLAPSE OF NATIONAL DRUG CONTROL POLICY AND A BLUEPRINT FOR REVITALIZING THE NATION'S COUNTERNARCOTICS EFFORT

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LEXISNEXIS SUMMARY:
... America is in the midst of a resurgent and dangerous drug crisis. ... These factors included the steep rise in juvenile and overall drug use (including both rising casual drug use and increasing regularity of use), the growing awareness that increased juvenile drug use is linked to rising juvenile crime, the absence of a long-promised White House Heroin Strategy, an objective reduction in interdiction efforts, an apparent lack of progress in source countries toward goals set forth for so-called source country programs, reports of lagging accountability in drug prevention programs, de-emphasis by the media on drug abuse and the overall rise in drug-related juvenile violence, and problems with interagency coordination of counter-narcotics. ... On the other hand, it is also clear that those who support increased funding and development of transit-zone interdiction, source country programs and law enforcement, to the exclusion of greater prevention and research into treatment, can not afford to miss the A-B-C-D connection between (A) increased prevention, (B) decreased casual use, (C) decreased addiction, and (D) decreased disease, death, and violent crime (since both casual and addictive use directly impact violent crime). ...

HIGHLIGHT: *The Nation is confronting a new drug epidemic marked by increased juvenile drug use and violent juvenile crime. In this Article, Robert B. Charles, Staff Director and Chief Counsel to the Subcommittee on National Security, International Affairs and Criminal Justice, of the House Committee on Government Reform and Oversight, examines the causes of this crisis and offers recommendations for ending it. He believes that the current epidemic is tied to the weak national drug strategy, which places too much emphasis on federally funded drug treatment and too little emphasis on drug interdiction, effective source country programs, demand reduction through prevention, and overall better coordination of the Drug War. In 1995 and 1996, Mr. Charles visited Mexico, Panama, Colombia, Bolivia, Peru, and the Caribbean Transit Zone for a hands-on evaluation of U.S. counternarcotics efforts. Insights from those visits are included in this Article.*

TEXT:
[*339] America is in the midst of a resurgent and dangerous drug crisis. After reviewing the relevant legal, legislative and operational histories, this Article concludes that the crisis stems from an ineffective National Drug Control Strategy

and weaknesses in existing policy. This Article first examines the crisis itself, then reviews weaknesses in the Nation's interdiction, prevention, law enforcement, source country and drug treatment strategies and programs. Lastly, a number of concrete ideas are advanced for creating an effective National Drug Control Strategy -- one that would directly confront and eventually face down the growing crisis. In a word, this Article offers a "blueprint" for revitalizing the Nation's counternarcotics effort.

Without an effective National Drug Control Policy, n1 embodied in a well-designed and properly implemented National Drug [*340] Control Strategy, n2 America's multi-tiered federal counter-narcotics initiative will almost certainly collapse. In truth, it appears that the collapse has already begun. Most experts agree that the Nation is confronting a renewed drug epidemic. This current epidemic is even more frightening than encounters with drug use in the 1970s because it appears to be closely linked to rising violent crime and it centers on children ages eight to seventeen.

If national attention does not soon return to the task of defining and vigorously implementing an effective National Drug Control Strategy, the Nation can expect to confront a wave of drug addiction and violent crime unparalleled in our Nation's history, and, some might argue, sufficiently damaging as to become culturally irreversible.

On the other hand, if the core components of an effective strategy can be rapidly identified, garner bipartisan support, and be conscientiously implemented, the prognosis for reversing the explosion in juvenile drug use and juvenile crime will be good.

II. A BRIEF HISTORY OF AMERICA'S ANTI-DRUG EFFORT

A. *From the Early 1970s Through 1988*

In the early 1970s, America experienced the enormous impact of illegal drugs. In June 1971, President Nixon told Congress that a national response to drug addiction would be required, since "the problem [had] assumed the dimensions of a national emergency." n3

Nixon's admonition was not ill-placed. By 1980, the use of illegal drugs was so widespread that anti-drug parent groups, including PRIDE and the National Family Partnership, were springing [*341] up. The previous year, more than half of all minors surveyed acknowledged drug use. n4

The parent groups, however, were not alone. During the early 1980s, then-First Lady Nancy Reagan became a leading spokesperson in the anti-drug or drug abuse prevention movement. Reagan soon became the movement's chief spokesperson. n5

During the mid-1980s, President Reagan also showed unprecedented leadership in what soon became known as the "war" against illegal drug use and those who trafficked in illegal drugs. n6

B. *The 1988 Anti-Drug Abuse Act and the Creation of the Office of National Drug Control Policy (ONDCP)*

In 1988, Congress passed the Anti-Drug Abuse Act of 1988, which established the Office of National Drug Control Policy ("ONDCP") and created the new position of "White House Drug Czar" or ONDCP Director. The Act also required the White House ONDCP Director to present an annual strategy with measurable goals and a Federal drug control budget to the President and Congress. n7

[*342] C. *The 1994 Violent Crime Control and Law Enforcement Act and Modifications to ONDCP*

In 1994, pursuant to the Violent Crime Control and Law Enforcement Act of 1994, n8 the Drug Czar was authorized to make recommendations to agencies during budget formulation. The goal of this provision was to improve resource targeting and policy consistency at Federal agencies that were charged with implementing the National Drug Control Strategy, as well as to heighten overall counter-narcotics coordination throughout the Federal Government. In addition, the 1994 Act authorized the Drug Czar to exercise discretion over two percent of the overall drug budget, subject to the approval of the appropriations committees. n9 Implicit in this award of new authority was the necessary presidential support for ONDCP to ward off predictable opposition from the agencies themselves, if not also from the Office of Management and Budget ("OMB").

D. *Other Recent Legislation*

A combination of frustration and creative thinking has resulted in several novel 1995 legislative measures. An amendment to a bill sponsored by Representative William Zeliff (R-N.H.) and Representative Mark Souder (R-Ind.), for instance, attempted to condition the release of foreign aid to Mexico on "the Mexican Government taking actions to

reduce the amount of illegal drugs entering the United States from Mexico, as determined by the Director of the Office of National Drug Control Policy." n10 While this measure passed the U.S. House of Representatives overwhelmingly, it was not included in a companion Senate bill and was struck in conference.

The effort by Representatives Zeliff and Souder was followed in early 1996 by a similar development in a Senate bill introduced on January 30, 1996 by Senators Alfonse D'Amato (R-N.Y.) and Dianne Feinstein (D-Cal.). This bill, S. 1548, would also sanction Mexico through restriction of applications by Mexican motor carriers to transport goods across the U.S. border, if [*343] the President and Secretary of Transportation were unable to certify to Congress that substantial progress had been made in counter-narcotics efforts. n11

Similarly, Representative E. Clay Shaw (R-Fla.) offered H.R. 2248, a bill "to authorize the imposition of trade sanctions on countries which threaten the health and safety of United States citizens by failing to cooperate fully with the United States policy regarding the reduction and interdiction of illicit drugs." Under this bill, which was not approved in the first session of the 104th Congress, the U.S. Trade Representative would be empowered to rescind or withhold certain trade benefits. n12

A variety of other legislation affects the development and implementation of National Drug Control Policy, including recent demand- and supply-reduction measures. n13

[*344] Other key pieces of 1995 legislation not yet signed by the President as of early 1996 include H.R. 728, which proposes to replace specific provisions in the 1994 Violent Crime Control Act concerning police, prevention and drug courts (Title 1; Title 3, Subtitles A through S, and X; and Title 5, respectively) with a flexible $ 10 billion block grant program, allocated at $ 2 billion per fiscal year between 1996 and 2000.

The flexibility in this law enforcement block grant is novel and intended to allow states to spend Federal monies on their choice of police officer training, hiring, and overtime pay, as well as new law enforcement technology, crime prevention programs, school security, drug courts, multi-jurisdictional task forces, and more anti-drug activities under the Byrne Grant program. This bill passed the House of Representatives on February 14, 1995. Special credit also goes to Representative William McCollum (R-Fla.), Chairman of the Crime Subcommittee of the House Judiciary Committee, for launching a hard-hitting anti-juvenile crime initiative in 1996.

On the edges of the process, but nevertheless important, are measures that would further enhance law enforcement and other aspects of the Drug War. For example, H.R. 1488 would heighten certain mandatory minimum sentences that involve a firearm; H.R. 2076 would enhance the provisions of H.R. 728 by adding [*345] nearly $ 2 billion in a Local Law Enforcement Block Grant Program, specifically targeted to drug-related activities. n14

In the Senate, S. 3, introduced by Senate Majority Leader Bob Dole (R-Kan.), would create a law enforcement block grant that also expands mandatory minimum sentences for those who use minors in commission of narcotics offenses or discharge of a firearm; and S. 1398, which amends the Controlled Substances Act to increase the penalty for trafficking in powder cocaine to the same level, attempting to damp out the argument about different mandatory minimum sentences for the two drugs by raising the lesser penalty. Together, these efforts reflect differing approaches to halting the onslaught of the drug abuse and drug-related crime. They also reflect a common growing concern for the Nation's basic security. n15

E. *Congressional Drug Policy Hearings from 1988 Through 1994*

More recently, legislative and investigative oversight hearings have been held on a variety of topics relating to national drug policy. Many of these hearings, for example the 1989 and 1990 Hearings of the Legislation and National Security Subcommittee of the House Committee on Government Operations, targeted "The National Drug Control Strategy." However, they also tended to drift toward problems afflicting a few specific programs (at more than fifty federal agencies and departments), highlight individual geographic concerns, and follow idiosyncracies of the Committee or Subcommittee Chairmen. n16

[*346] On balance, these hearings advanced the issue of drug abuse and drug trafficking in public dialogue, but did not arrive at any guiding or governing principles that might legitimately form the basis for an effective National Drug Control Strategy. Where firm positions were taken by the Chairman, they tended to reflect the view that demand- and supply-reduction are in competition and that demand-reduction efforts, particularly drug treatment, should prevail. Thus, then-Chairman John Conyers, Jr., (D-Mich.), of the Legislation and National Security Subcommittee opened one hearing with the proclamation that, "it has become apparent that the focus of the drug strategy must be on reducing demand." n17

[*347] Some national hearings have even been wasteful and counter-productive. Ironically, and contrary to the body of scientific evidence describing what narcotics are, how narcotics severely and subtly impair the human mind and body, and how devastating effects of drug use can be in the nearterm (e.g., cardiac arrest, mental impairment, addiction, death) and long-term (e.g., reduced motivation, addiction, mental and physical process deterioration, death), one 1994 hearing even gave witnesses an opportunity to blithely opine in favor of legalizing dangerous narcotics. n18

At that hearing, witnesses were encouraged to explore the legalization of marijuana, PCP (phencyclidine), and cocaine.Putting aside the body of narcotics science demonstrating psychological and bodily harm, n19 the inchoate criminality of non-medical [*348] narcotics use, the heightened impact of narcotics on children, and the deep societal and moral implications of government encouragement of narcotics use, one witness opined that marijuana's only attraction is that it is "illicit" and that "no one knows" what would happen to the crime rate if cocaine were legalized. The same witness suggested that making cocaine available in large doses to addicts would assure "illicit cocaine dealers would be put out of business." n20 The naivete, as well as the uninformed and misleading nature of that testimony, did little to enhance the public dialogue.

While indulgent and defeatist arguments for drug legalization and decriminalization have been bandied about at different points during the course of the Nation's historic fight against drug abuse and international drug trafficking, n21 most recently by President Clinton's then-Surgeon General, Jocelyn Elders -- these ideas [*349] have seldom been taken seriously. The empirical reasons for dismissing the legalization argument, beyond the body of science supporting direct and indirect health damage resulting from narcotics, n22 the immorality of drug use, and broader social issues, are: (1) the close proven correlation between high street availability, high purity, low price and increased casual drug use, particularly use by children ages twelve to seventeen; n23 (2) the proven link between violent crime and drug use, in particular user-crime, rather than dealer- or internecine gang-crime; n24 and [*350] (3) the clear relationship between casual drug use and addiction, including the percentage of casual users who will, by virtue of regular or continuing use, become addicted (with the attendant harms of addiction). n25

In response to the suggestion at the 1994 hearing testimony that legalizing cocaine would somehow mean "illicit cocaine dealers would be put out of business," the shortest answer is not the economic reality that as cocaine use increased, production in the source countries would also increase or that most drug-related crime is not dealer-related. n26 The shortest answer is that, more people would die (directly and indirectly) as use and addiction increased, n27 and they would die both at the hands of legal dealers and those continuing to promote a higher potency black market. Of course, crime associated with any act considered criminal (including murder) could be statistically reduced overnight by declaring the act no longer a crime; victory on those terms would be an obvious illusion. For better or worse, the national dialogue, including the rare congressional hearing, has periodically indulged in a counter-productive discussion of drug legalization. However, until we begin seriously considering the legalization of murder, child abuse, and similar crimes, there is no room in the public dialogue for discussing the legalization of narcotics.

[*351] F. *General Accounting Office Investigations*

It should be noted that, while hearings in 1995 established new ground in the process of reviewing the National Drug Control Strategy, and presented findings based partially on new General Accounting Office ("GAO") investigations, earlier GAO investigations were helpful in guiding national policy. n28

G. *Other Congressional Anti-Drug Efforts*

Creative thinking has also opened non-legislative channels. One of the most promising is the formation of the U.S. House Bipartisan Drug Policy Working Group, which in a closed session recently heard from FBI Director Louis Freeh, DEA Administrator Thomas Constantine, and ONDCP Director Lee Brown. That unprecedented November 1, 1995 meeting drew in excess of twenty-five members of the House and a nearly even split between Republicans and Democrats. On February 29, 1996, the Group met again for nearly two hours with newly confirmed White House Drug Czar, General Barry McCaffrey, again in closed session. The Group is co-chaired by Representative Zeliff and Representative Charles Rangel (D-N.Y.). Another promising group is the newly created Senate-House Drug Policy Task Force, jointly chaired by Senator Orrin Hatch (R-Utah), Senator Charles E. Grassley (R-Iowa), Representative Zeliff, and Representative Henry Hyde (R-Ill.). The Task Force was convened by Majority Leader Dole (R-Kan.) and House Speaker Newt Gingrich (R-Ga.). A third major initiative is the spear-heading of community anti-drug coalitions by Representative Rob Portman (R-Ohio). This highly successful initiative may soon be replicated throughout the country, and involves creating local synergies by bringing together often disparate groups behind one anti-drug mission.

[*352] II. PREDICATE FOR ACTION: A NATION IN CRISIS

In 1995, congressional oversight hearings conducted by the Subcommittee on National Security, International Affairs and Criminal Justice (hereinafter "National Security Subcommittee"), of the Government Report and Oversight Committee, broke new ground in the exploration of National Drug Control Policy. Those hearings, chaired by Representative Zeliff, in combination with recent nationwide studies and other reliable documentary evidence, provide the statistical and evidentiary underpinning for the analysis that follows. n29

The National Security Subcommittee initiated its investigation of the design, coordination, and implementation of the National Drug Control Policy in early 1995. n30

Even in early 1995, a number of factors suggested a major deficiency in how the nation was approaching the drug war. These factors included the steep rise in juvenile and overall drug use (including both rising casual drug use and increasing regularity of use), the growing awareness that increased juvenile drug [*353] use is linked to rising juvenile crime, n31 the absence of a long-promised White House Heroin Strategy, n32 an objective reduction in interdiction efforts, n33 an apparent lack of progress in source countries toward goals set forth for so-called source country programs, n34 reports of lagging accountability in drug prevention programs, n35 de-emphasis by the media on drug abuse n36 and the overall rise in drug-related juvenile violence, n37 and problems with interagency coordination of counter-narcotics. n38

A. *Juvenile Drug Use Exploding*

What becomes apparent upon a review of all available factual material is that -- as of early 1996 -- the nation is in the grips of an unprecedented juvenile drug use explosion, replete with the societal costs and the correlations any observer would expect from such a development.

Specifically, the evidence is now nearly incontrovertible that drug use among the nation's juvenile population has risen at an alarming rate across American society over the past three years. Reputable 1994 nationwide surveys measured disturbing increases [*354] in drug use and acceptability, especially among the nation's youth.

According to the 1994 *Monitoring the Future Study*, conducted by the University of Michigan, thirteen percent of eighth-graders experimented with marijuana in 1993, about twice the 1991 level. Experimentation among tenth-graders increased by about two-thirds the previous three years, and daily use among high school seniors was up by half over 1993 levels. n39

In addition, lifetime cocaine use increased among eighth and tenth graders, crack use increased among eighth graders, lifetime use of hallucinogens (including LSD) increased for tenth graders, and lifetime, annual and current use of heroin increased among eighth graders. Overall, drug use showed a marked upturn among the junior and senior high school students surveyed. n40

This same study, which annually surveys approximately 16,000 high school seniors, the same number of tenth graders, and approximately 17,000 eighth graders, n41 came to other disturbing conclusions. The 1994 survey not only found that overall lifetime use of drugs was up; it found a declining number of students who viewed use of crack, cocaine, LSD or heroin as risky. n42

[*355] Increasing use of illegal drugs was also reported by the Drug Abuse Warning Network (DAWN) using data on drug-related emergencies during 1993, collected from emergency rooms around the country. Overall, that data showed an eight percent increase in drug-related emergency room cases between 1992 and 1993, with heroin overdoses accounting for forty-five percent of the increase. Cocaine use also reached an all-time high, having more than doubled since 1988, and marijuana emergencies increased twenty-two percent between 1992 and 1993. n43

The latest surveys indicate that illegal drug use has continued to rise since 1994. The National Household Survey released in late 1995 shows that overall drug use among children ages twelve to seventeen jumped nearly fifty percent in 1994, from 6.6% to 9.5%. n44 The National Pride Survey of 200,000 students shows that one in three American high school seniors now smokes marijuana, that there has been a thirty-six percent increase in cocaine use among students in grades nine through twelve since 1991-92, and that hallucinogen use by high schoolers has risen seventy-five percent since 1988-89. n45 Additionally, the October 1995 DAWN data shows that, in 1994, "cocaine-related episodes reached their highest level in history," registering a "15 percent increase from 1993 . . . and 40 percent increase from 1988 . . . ." Marijuana or hashish-related emergencies rose thirty-nine percent from 1993 to 1994, while total drug-related emergency cases rose ten percent between 1993 and 1994. n46

B. *Historical Context: Prior Decade of Falling Use*

The increase in juvenile drug use over the past three years is especially disheartening in light of the reductions witnessed under the Reagan and Bush Administrations. Between 1981 and 1992, overall drug use fell precipitously, as coordinated federal, state, community, and parental counter-narcotics activity intensified, [*356] and Presidents Reagan and Bush, as well as First Lady Nancy Reagan, provided outspoken leadership on the issue. n47

In combination with nationwide grassroots parent groups, such as Pride and the National Family Partnership, Nancy Reagan's"Just Say No" prevention message began the push to reduce drug use in the early 1980s. Reagan's effort was supplemented by federal drug prevention funding in 1987, and was coordinated with the first concerted drug interdiction program in the late 1980s. n48

Aided by new counter-narcotics programs at the Departments of Defense and Justice, the Drug Enforcement Administration, U.S. Customs Service, Border Patrol, and State and Local law enforcement agencies, then-Coast Guard Commandant Admiral Paul Yost coordinated and implemented a drug interdiction effort based on the increased flow, or "pulsing," of federal interdiction resources into the Transit Zone at high drug trafficking times (for example, in high harvest seasons). n49

Together, these prevention, law enforcement, and interdiction efforts yielded results. "Monthly cocaine use dropped from nearly 3 million users in 1988 to 1.3 million in 1990 . . . . Between 1991 and 1992 overall drug abuse dropped from 14.5 million users to 11.4 million." n50 The perceived risk of drug use rose, as did prices, while availability and purity fell. n51

[*357] C. *Drug-Related Violent Juvenile Crime Rising*

The increase in juvenile drug use is all the more alarming because juvenile drug use and juvenile violent crime are closely correlated and, predictably, feed upon each other. In September 1995, the Justice Department's Office of Juvenile Justice and Delinquency Prevention ("OJJDP") reported that "1 in 3 juvenile detainees were under the influence of drugs at the time of their offense." n52 Moreover, there should be no understating the relationship between rising juvenile crime and rising juvenile use of marijuana. The 1995 OJJDP report notes that, "the level of marijuana use in 1993 [i.e., positive test at arrest] ranged from 14% to 51% [among the twelve test sites] of the juveniles tested, with an average value of 26% . . . substantially above the 1992 average of 16.5%." n53

Moreover, according to OJJDP, "after years of relative stability, juvenile involvement in violent crime known to law enforcement has been increasing," and "juveniles were responsible for about 1 in 5 violent crimes." n54 Other factors suggest that drug use itself, independent of the population under study, is closely correlated with non-drug offense crime. n55

D. *Media and Presidential Attention Missing*

The difficulties of reducing drug use have been exacerbated by the fact that the drug issue has fallen into relative obscurity since the late 1980s. Objective indicators of the amount of attention that the media, national leaders, and the President, in particular, are devoting to the anti-drug effort reveal lower interest [*358] than at any other time in recent history. Experts say that media coverage of the Drug War, which peaked in 1989, has been barely evident since. n56

Presidential leadership has been equally anemic. In 1993, President Clinton made seven addresses to the nation; none mentioned illegal drugs. The President's 1993 presidential papers reveal thirteen references to illegal drugs out of a total 1,628 presidential statements, addresses, and interviews. Of 1,742 presidential statements and other utterances in 1994, illegal drugs were mentioned only eleven times. n57

E. *1993-1996 Budget Cuts in Counter-Narcotics Programs*

Despite the successes in the 1980s and early 1990s, support for counter-narcotics efforts, especially for interdiction, has been declining, as evidenced by the Administration's 1993, 1994, 1995, and 1996 budget priorities and the relative indifference of the 103d Congress on this issue. In fact, the Clinton Administration has presided over a substantial reduction in resources committed to important supply-reduction programs, and has underemphasized crucial demand-side prevention efforts. In early 1995, key budget numbers were already well below prior levels, despite the perception that these marks defined the minimum resource requirements for effective conduct of the Drug War. n58 Sadly, even the election-year 1996 numbers are much the same. n59

While the total anti-drug budget rose from $ 1.5 billion in fiscal 1981 to $ 13.2 billion in fiscal 1995, n60 ONDCP reports a drop in both drug interdiction and international program funding, n61 and concedes a significant shift among demand reduction programs toward an emphasis on drug treatment. Under the Clinton Administration's re-prioritization,

the drug interdiction budget [*359] fell from $ 1.511 billion in FY 1993 to $ 1.312 billion in FY 1994. President Clinton's FY 1994 budget request rolled back interdiction spending by $ 200 million. In FY 1995, the President rolled back interdiction spending another $ 18 million, to $ 1.293 billion, and in FY 1995, he proposed an additional cut of $ 15 million to $ 1.278 billion. n62

At the same time, international or source country counter-narcotics funding fell from a high of $ 523 million in FY 1993, to $ 329 million in FY 1994, and to a low of $ 309 million in FY 1995, rebounding only slightly to $ 399 million in the presidential request for FY 1996. n63 These and other budget numbers, as well as specific asset and personnel cuts, are discussed further below.

F. *Shifting National Drug Control Policy Priorities*

Another sign of, and cause for, the juvenile drug use and juvenile crime crisis is the Clinton administration's embrace of two new drug policy priorities. Drug treatment for a limited number of older, chronic addicts has been favored over accountable, juvenile drug prevention; and the Administration has made a public shift away from transit zone interdiction, favoring source country programs, but has not shifted the resources necessary to sustain their stated priority on source country programs. These conscious shifts in the Administration's 1994 and 1995 National Drug Control Strategies have been a material cause of recent declines in policy effectiveness.

First, on the consumption, or demand-reduction side, the new policies comprise a shift of available resources toward treatment programs for hardcore drug users, and away from prevention programs for casual and non-users. Specifically, the 1995 White House National Drug Control Strategy identifies first on its list of "National Funding Priorities for FYs 1997-99" the "support programs that expand drug treatment capacity and services so that those who need treatment can receive it." n64 To this end, the President has markedly increased treatment resources. In FY [*360] 1993, treatment funding stood at $ 2.339 billion. The figure increased to $ 2.399 billion in FY 1994, to $ 2.647 billion for FY 1995, and the President's request for FY 1996 was at the all-time high of $ 2.827 billion. n65 In the April 1996 proposal for FY 1997, the President topped even the prior record, seeking $ 2.908 billion dollars for treatment. n66

Experience now indicates that these demand-reduction resources were poorly targeted. The President's 1995 Drug Control Strategy acknowledged the increase in casual drug use among the Nation's youth but concluded: "Anti-drug messages are losing their potency among the Nation's youth." n67 This conclusion, coupled with increased spending on drug treatment, represents a fundamental misunderstanding of the importance of prevention programs targeted at the population most at risk.

The stated goal of shifting these resources to effective source country programs appears never to have occurred. The 1994 and 1995 White House Strategies represent a reduction in interdiction or transit zone counter-narcotics programs, as discussed in greater detail below.

G. *Movement Away from Short-Term Measurable Objectives*

The Clinton White House Drug Strategies for 1993, 1994, 1995, and 1996, depart from the statutory requirement of "shortterm measurable objectives," n68 offering instead broad, prescriptive goals and precatory language, such as: "Reduce the number of drug users in America." n69

The Anti-Drug Abuse Act of 1988 clearly sets forth four statutory requirements. ONDCP is required to:

> (A) include comprehensive, research-based long-range goals for reducing drug abuse in the United States; (B) include short-term measurable objectives which the Director determines may be realistically achieved in the 2-year period beginning on the date of the submission of the strategy; (C) describe the balance between resources devoted to supply reduction and demand reduction; and (D) review State and local drug control activities to ensure that the United States [*361] pursues well-coordinated and effective drug control at all levels of government. n70

While there are serious questions as to whether sections A and D arebeing performed (see below), section B clearly seems to have warranted no attention from ONDCP. This is true in President Clinton's 1996 strategy, as it was in 1993, 1994, and 1995.

Together, the indicia of mounting drug use and juvenile crime, in combination with the policy shifts, suggest that a crisis is indeed upon us.

III. IDENTIFYING CAUSES AND EXAMINING FEDERAL PROGRAMS

A. *Supply-Reduction Policy and Programs*

Supply-reduction consists essentially of drug interdiction efforts, coordinated among the Defense Department ("DoD"), n71 U.S. Coast Guard, n72 Drug Enforcement Administration ("DEA"), n73 Federal Bureau of Investigation ("FBI"), n74 U.S. Customs, n75 [*362] State Department, n76 U.S. Border Patrol, n77 and other supporting law enforcement agencies, n78 as well as the so-called source country programs, which are coordinated in-country and intended to stem the flow of illegal drugs at the source.

A review of testimony and documents surrounding the Nation's supply-reduction policy suggests bipartisan support for interdiction. Just as interdiction and law enforcement experts recognize the central role played by parental, community, state, and federal drug prevention efforts, prevention experts acknowledge the importance of law enforcement and interdiction efforts in creating and maintaining an effective use-reduction strategy.

Drug interdiction assets, funding, and emphasis have fallen substantially over the past three years, with foreseeable results. This development is in sharp contrast to the concerted interdiction [*363] efforts launched by the Reagan and Bush Administrations between 1984 and 1990.

1. Successful 1980s and early 1990s Interdiction Efforts

Testimony offered in early 1995 by Admiral Paul Yost, former United States Coast Guard Commandant and the man who headed the nation's interdiction effort between 1984 and 1990, is revealing. It suggests reasons for optimism in the area of interdiction, because his coordinated effort had a positive effect on domestic drug use, drug availability, drug purity, and the rise in street drug prices during the late 1980s. n79

In hearings before the National Security Subcommittee in early 1995, Yost testified that the Nation experienced a "major buildup in drug interdiction . . . from 1984 through 1990, and this interdiction effort successfully interrupted the flow of bulk marijuana by sea and cocaine by air over the water routes [of the Caribbean]." n80

Yost testified that "strong interdiction and law enforcement [during the period 1984 to 1990] were providing a climate that made it clear to the [drug] trafficker: 'This is wrong, and your chances of being intercepted are very high.'" n81 He also explained the need for a "theater commander," and how he had aggregated Coast Guard and interagency assets to implement a sub-strategy called "pulses." The "pulses" strategy involved concentrating all interdiction resources in a particular region at pre-planned times, for example along Caribbean trafficking routes at the height of the marijuana harvest season. n82

2. 1993-1995 Interdiction Cuts and Asset Removal

While some transit zone interdiction assets were redeployed to the Persian Gulf in 1991, the overwhelming reduction in the interdiction force structure has occurred between 1993 and 1995. Objective indicators of federal support for the counter-narcotics [*364] effort show a substantial reduction in resources committed to key areas. Although the policy shift has been defended by the Administration, key budget numbers are below prior highwater marks. This conclusion is supported by evidence from the President's 1995 and 1996 drug interdiction budgets, the Office of the United States Interdiction Coordinator, and 1995 reports from the General Accounting Office, as well as from 1995 congressional testimony.

There have also been reductions at ONDCP that appear to have affected implementation and coordination of supply-and demand-reduction programs. While the total anti-drug budget rose from $ 1.5 billion in FY 1981 to $ 13.2 billion in FY 1995, n83 ONDCP itself lost substantial resources in 1993 and reported a substantial drop in funding for both drug interdiction and international programs. n84

The raw budget numbers clearly display a decrease in funding. Drug interdiction's budget authority fell from $ 1.511 billion in FY 1993 to $ 1.312 billion in FY 1994, a $ 200 million reduction by President Clinton in the FY 1994 budget. In FY 1995, the interdiction budget was cut by another $ 18 million to $ 1.293 billion. In FY 1996, the President's request for drug interdiction funding fell another $ 15 million to $ 1.278 billion. n85 While the 104th Congress appears to have been unreceptive, these figures also demonstrate a reduced White House commitment to drug interdiction.

Despite a rhetorical shift to source country programs, even international counter-narcotics funding fell during this period, from a highwater mark of $ 523 million in 1992 to $ 329 million in FY 1994, and then to $ 310 million in FY 1995, recovering only slightly to about $ 400 million in President Clinton's requests for FY 1996 and FY 1997. n86

[*365] Interdiction cuts have also been reflected in the loss of concrete and identifiable assets. According to 1995 testimony from Admiral Yost, the United States has recently experienced a "tragic dismantling" of its interdiction efforts, such that today "there are several orders of magnitude less effort spent on drug interdiction." n87 In particular, "ship days and aircraft hours are drastically reduced," and "all of the Coast Guard jet aircraft, the Falcons with the F-16 intercept radars, were taken away from interdiction . . . ." n88

Admiral Yost testified to the fact that "three Coast Guard E-2C airborne early warning aircraft have been turned back to the Navy and used for other purposes," and that "the Coast Guard Air Station at St. Augustine, Florida, which was established to support these three multimillion dollar aircraft, is now closed." Yost indicated that he believed some of the E-2Cs were even being "decommissioned." n89

On top of this, "the Coast Guard C-130 airborne early warning aircraft has been turned over to the Air Force, stripped of its equipment, including a dome-mounted radar, and is now used for transportation of cargo," Yost reported. Finally, "the new Command, Control, Communications and Intelligence Center has been closed, and its duties are performed elsewhere." n90

The impact of the loss of interdiction assets has been described in different ways. For example, the Nassau DEA Office of Operation BAT (Bahamas, Turks and Caicos, abbreviated as [*366] "OPBAT") reported in 1995 that, "while no specific intel[ligence] source indicates that traffickers perceive the removal of the aerostats [radars] from the Bahamas as a weakness in law enforcement detection capability, it stands to reason that a reduction in visible detection resources would equate to 'safe' illicit activity," and the Nassau DEA OPBAT Office partially attributed the recent shift in trafficking patterns and the increase in "trafficking events per month," to removal of the aerostats. n91

A further indication of disarray in interdiction asset policy appears in an unclassified December 18, 1995 Department of Treasury memorandum to the Director of the Domestic Air Interdiction Coordination Center ("DAICC") from a U.S. Customs Service official. This memorandum concerns the status of over-the-horizon radars, or R.O.T.H.R. radars. After the Administration removed key aerostats from service, it proposed deploying ground-based over-the-horizon radars as the primary, intelligence-gathering substitute technology. Primary reliance on R.O.T.H.R. radars, without other intelligence assets, such as aircraft equipped with look-down radars or redeployment of the aerostats, raises serious questions. According to the memorandum, R.O.T.H.R. radars are "a good *support* system . . . [and] can be an invaluable tool in assisting the detection and tracking of targets, but due to . . . operational limitations (even if all the enhancements are successful and funded for O&M), [R.O.T.H.R.] cannot replace a fixed or airborne radar system." n92

Compounding the problem created by the Nation's reduced radar coverage in the transit zone and source countries, it now appears clear that one R.O.T.H.R. must now be deployed in Puerto Rico to provide effective radar coverage of narco-trafficking in and from northern South America, for example, to track flights originating in Colombia and destined for Mexico or drop points in the Caribbean. Also clearly needed now are three or four ground-based radars in Southern Peru, to halt flights leaving southern Peru, transiting Brazil, and landing in Colombia, from which cocaine is shipped to Mexico and the United States. n93

[*367] If testimony from the Drug War's former operational commander and other informed observers were not persuasive enough, ONDCP's own reports and statements confirm the profound nature of the shift away from drug interdiction and toward other priorities.

The 1995 National Drug Control Strategy Budget Summary confirms a drop in Department of Defense flight hours from 50,624 in 1994 to 50,000 in 1995, with the same number projected for 1996. It also shows ship days down from 2,268 in 1994 to 1,545 in 1995, with the same number projected for 1996. n94 Furthermore, the Budget Summary shows that National Guard container search workdays dropped from 227,827 in 1994 to 209,000 projected for 1996, while other drug interdiction-related National Guard workdays fell from 597,385 in 1994 to a projection of 530,000 in 1996. n95

3. Corroborating a Reduced Emphasis on Interdiction: The 1995 USIC Memo and Testimonial Evidence

Strong support exists for the conclusion that interdiction efforts have been consciously de-emphasized by the current Administration. For example, an unclassified memorandum originating in the Office of the United States Interdiction Coordinator ("USIC") dated June 1995 offers a detailed assessment of the Clinton reductions. The USIC memoran-

dum lists two sets of assets removed from the interdiction effort by the Clinton Administration: "counterdrug assets removed from USCG [United States Coast Guard] inventory to comply with FY94 budget reductions," and "other assets removed prior to 1994." n96

Initially, the USIC memorandum lists: five "HU-25 Falcon jet interceptors," one "Medium Endurance Cutter," three "Surface Effect Ship (SES) patrol boats," forty-nine personnel due to an "end of participation" in a Miami-based C3I [Command, Control, Communications and Intelligence] station, and twenty-four more personnel due to the "disestablished . . . Caribbean Squadron [*368] Staff." Overall, the USCG interdiction assets removed amounted to a reduction of $ 9,337,915 and 306 total personnel as well as $ 21,151,338 in "recurring costs." n97 On top of this, the USIC memorandum notes that, although the Customs Service "has now consolidated the former functions of C3I East and C3I West into the Domestic Air Interdiction Coordination Center (DAICC) located at March AFB [Air Force Base] in California," the "DAICC facility faces serious manning shortages." n98

As a secondary matter, the USIC memorandum lists assets removed "prior to 1994," including: four "E2-C Hawkeye AEW aircraft (1 lost to a crash; 3 returned to the Navy)," and one "EC130-V AEW aircraft (delivered to USCG in FY92. Transferred to DoD in 1993 for lack of operations & maintenance funding)." Additionally, the memorandum observes, in discussing the EC130-V AEW (intelligence gathering) aircraft transferred from USCG interdiction to DoD, "The rotodome was removed from the airframe. Last we heard, the airframe was in storage," adding "DoD retired all of the . . . sea-based aerostats." n99

In addition to the evidence offered by the USIC memorandum, an array of drug policy experts came to the fore in 1995 to offer what is becoming a consensus, namely that the interdiction cuts were too deep and have led to serious detrimental effects.

Testimony offered by former Acting ONDCP Director John Walters, former ONDCP Director Bill Bennett, and former Bush and Clinton DEA Administrator Judge Robert Bonner confirmed the loss or decommissioning of interdiction assets during the Clinton Administration.

In March 1995, Walters testified that "the drug problem is simply not a part of the foreign policy agenda of the United States under President Clinton -- there is no carrot and no stick facing the countries from which the poison destroying American lives every day comes." He noted that the Administration's deemphasis of international counternarcotics "fuels calls in other countries for abandoning anti-drug cooperation." n100

Sadly, it is clear that a precious window of opportunity in the source and drug transit countries is currently being lost. In Peru, Bolivia, and Colombia, source country programs -- including coca [*369] crop eradication, alternative crop production, creation of highintegrity "vetted" law enforcement units composed of indigenous citizens, and crucial DEA, State Department, DOD, and intelligence-led efforts -- are badly underfunded. This is occurring just as Peru's shoot-down policy has effectively shut off the "air bridge" between Peru (where two-thirds of the world's coca is grown) and Colombia (where coca is processed). Thus, just as Peru's policy has driven the price of a narco-trafficking flight from $ 25,000 up to $ 200,000 and caused the price of coca leaves in Peru to fall (resulting in Peruvian coca farmers abandoning twenty to forty percent of their fields), the Clinton Administration's lack of commitment to combatting drugs in the source countries may prove disastrous.

Other South American countries' counter-narcotics activities also reveal the need for Washington to restore its once-vigorous war on drugs abroad. In Mexico, despite lagging efforts in prior years, the Mexican Congress and President are poised to enact stiff, new money-laundering, organized crime, conspiracy, wiretap, and asset forfeiture laws. This broad Mexican effort should compel a heightened U.S. commitment to counter-narcotics training for Mexican law enforcement personnel, targeted intelligence sharing, and increased counter-narcotics support.

A similar U.S. commitment is essential and timely for Colombia. The 1995 efforts of General Serrano, head of the Colombian National Police, and Prosecutor General Valdivieso have finally broken the Cali Cartel and have begun to root out official corruption. While a constitutional crisis still surrounds President Semper, the dedication of these two men is striking. Finally, Fujimori's success in Peru during 1995, and the advances made by Bolivia's elite counternarcotics military force, "UMOPAR," call for a return to greater efforts against the drug trade by the United States.

Moving to intelligence, Walters testified that President Clinton's interdiction policy is "destroying the intelligence support to the drug war," noting that the President last year cut $ 600,000 in intelligence funding and took other measures to redirect resources away from intelligence for the drug war. n101 The USIC memorandum referred to previously buttresses Walter's assessment. n102

[*370] In addition, the potential for increasingly effective planning and coordination of counter-narcotics operations by U.S. Southern Command was demonstrated in the late-1995 effort, called "Operation Green Clover," which coordinated militaries from several South American nations (as well as a variety of U.S. agencies). The success of Green Clover argues strongly for increased U.S. intelligence gathering and regional coordination, if not a full-fledged international counter-narcotics center in Panama. Unclassified intelligence assets still needed include at least two P-3 AEW aircraft, multiple ground-based radars in Southern Peru and Mexico, and the R.O.T.H.R. in Puerto Rico. Also badly needed is State Department support for the "vetted units" and for more DEA agents in the region.

Regarding overall force reduction, Walters testified that "the military and other interdiction agencies have received a 50 percent force reduction in 1994 that has caused over a 50 percent reduction in their ability to interdict drugs . . . [in] the transit zone." n103 He sent a strong signal for reform by stating that, "if these trends continue, by 1996, the Clinton Administration will have presided over the greatest increase in drug use in modern American history." n104 As the end of 1996 approaches, there is no reason to revise Walter's assessment.

Bennett and Bonner offered similar assessments in recent testimony. Bennett outlined how the Administration's 1995 strategy would "cut . . . more than 600 positions" from the DEA and other agencies, cut "more than 100 drug prosecution positions in the U.S. Attorney's offices," and "cut . . . drug interdiction and drug intelligence programs from FY 1994 levels." n105 Bennett also testified that, "last year [1994], the Clinton Administration directed the U.S. Military to stop providing radar tracking of cocaine-trafficker aircraft to Columbia and Peru," a policy Congress "had to reverse," and stressed that "massive policy failures" have plagued the Clinton Administration. n106

Judge Bonner argued that drugs pose "a serious threat to the well-being of our nation," n107 noting that "our national drug strategy [in the 1980s and early 1990s] was working . . . ." n108 Bonner [*371] further observed that, "as the resources for enforcement and interdiction have been cut, the price of cocaine has gone down and the estimated number of heavy users has gone up." n109 The linkage between reduced resources for interdiction, lower drug prices and increased usage should give pause to those who have favored only increased demand-reduction. Judge Bonner also testified that, while the Cali Cartel is "supplying between 80 and 90 percent of all of the cocaine that reaches the United States[,]" n110 the Clinton Administration "has utterly failed to appreciate the value of strong international drug law enforcement as a major component in an effective drug control strategy . . . ." Judge Bonner called on the President to "reverse this trend and start leading our nation's anti-drug efforts." n111

4. Further Corroboration: Admiral Kramek's Voice in the Wilderness

Confirming the depth of concern about the Administration's new direction is a piece of unclassified correspondence between the Interdiction Coordinator, Admiral Robert Kramek, and ONDCP Director Lee Brown from December 1994. It reveals Admiral Kramek's view that a "consensus" of agency heads at that time believed, "we need to restore assets to the interdiction force structure" and "must return to the 1992-1993 levels of effort" to keep the Drug War on track. This recommendation flew in the face of Presidential efforts to reprogram or shift funding to drug treatment. n112

Pointedly, Admiral Kramek addresses the drug problem as a threat to "national security." Specifically, the Interdiction Coordinator wrote,

> I believe it appropriate that we meet with the President and National Security Advisor as soon as possible to brief them on the results of our conference and discuss the current state of implementation and national strategy . . . . Of key importance to this meeting is the determination of priority of *counting narcotics trafficking as a threat to national security of the United States* as evaluated against other threats to our security that compete for resources. n113

[*372] In subsequent Congressional testimony on June 27, 1995, Admiral Kramek offered implicit criticism of President Clinton's reduced interdiction efforts by stating, "When the [smugglers] see our foreign policy priorities changing and making drug interdiction much lower on the list than other things, they're quick to take advantage of that." n114 He explained that "when they see funds being cut back for things like AWACS and radars and ships in the transit zone, they're quick to take advantage of that." n115 Defending a return to interdiction, Kramek noted that interdiction returns twenty-five to one in net benefits to the public for every dollar spent, a compelling, new statistic in the national dialogue. n116 Kramek commented further on the shift from a transit zone strategy to a source country strategy, saying that "the source country strategy . . . is starting to take hold, [but it] is not robust enough, in my view, for us to reduce assets in the transit zone yet." n117 Since key interdiction assets were already gone in June 1995, Admiral Kramek's

critique calls the current strategy into serious question, especially given the high regard in which the Admiral is held by Democrats and Republicans in Congress.

Adding weight to Admiral Kramek's 1994 letter and 1995 testimony, and underscoring the need to revitalize our interdiction efforts, is a letter sent to Admiral Kramek by Commissioner of U.S. Customs George J. Weise on December 19, 1995. In this letter, the Commissioner of Customs informed Admiral Kramek that "the demand for the Customs P-3 Early Warning (AEW) aircraft in the detection mission is increasing dramatically." n118 Accordingly, Weiss enlisted Kramek's support for increased funding of intelligence-gathering P-3s. Weiss also cited a letter from Admiral Kramek to a Special Assistant to the President in which the U.S. Interdiction Coordinator noted that Customs had "only four such aircraft in our fleet," essentially confirming the President's low priority on intelligence-gathering assets. n119

Perplexingly, testimony in April 1995 by then-White House Drug Czar Lee Brown revealed that Brown held a strikingly [*373] different view of the need for interdiction. Moreover, despite the Interdiction Coordinator's explicit 1994 request, Brown did not present to the President the consensus view of agency heads that increased interdiction efforts were needed. n120 In fact, Brown apparently never conveyed to the President Admiral Kramek's considered view. Brown conceded the Administration's intention to execute a "controlled shift . . . in interdiction from the transit zone to the source countries," but was unable to offer evidence of new resources appearing in the source countries, or any results of the alleged shift. n121 Brown sought to justify the reduced interdiction effort by suggesting, without elaboration, that "random patrols produce random results." n122

5. Other Supply-Reduction Policy Deficiencies

A. *No heroin strategy*. Regarding heroin, President Clinton promised in November 1993 that he would enact a National Heroin Strategy within 120 days. Two years later, he signed an uninspired heroin strategy in an unannounced ceremony. n123 While Brown testified in early 1995 that the "growing availability of cheap high purity heroin raises concerns about the possibility of another heroin epidemic . . . .," n124 President Clinton did not sign a heroin strategy until November 1995, and has subsequently let the strategy languish without implementing guidelines.

Not surprisingly, a recent study by the General Accounting Office found that the approach to heroin pursued by the Clinton Administration has been deficient. Combatting the Burma-based heroin trade has been impaired by the United States' reluctance to engage in constructive dialogue with the repressive Burmese government. Consequently, the United States has been forced to rely on United Nations drug control efforts in the region. However, the U.N. policy has been flawed. In particular, GAO found that, "the [U.N.] projects have not significantly reduced opium production because (1) the scope of the projects has been too small to have a substantive impact on opium production, (2) the [*374] Burmese government has not provided sufficient support to ensure project success, and (3) inadequate planning has reduced project effectiveness." n125

b. *Source country programs underfunded and mismanaged until June 1995*. A second major reason for worry about the prevailing source country-oriented National Drug Control Strategy stems from two basic findings. First, while there are some highly effective programs being implemented in Colombia, Bolivia, Peru, and most recently, Mexico, by the DEA, the A.I.D., the State Department and DoD, with vital assistance from the U.S. intelligence community, these programs have often been under-manned, under-equipped, and under-funded. A recent first-hand examination of some of these programs found each in need of better operational support and more consistent, long-term funding. These responsibilities lie equally on the President and Congress. Second, during the first two-and-a-half years of the Clinton White House, there have been sporadic reports of mismanagement, confusion and poor coordination in the source country programs. Those findings emerged again in June 1995 Congressional hearings, when a GAO official exposed pockets of mismanagement and continuing resource gaps in the source country programs. n126

As background, the President's 1995 National Drug Control Strategy not only refocused demand-reduction resources on drug treatment, but -- in theory at least -- refocused supply-reduction resources on source country programs. This is what Administration representatives term the "controlled shift." n127

Deflecting a certain degree of responsibility away from ONDCP, the 1995 ONDCP Strategy stated that the National Security Council ("NSC") conducted a "lengthy review" of drug trafficking in 1993 and concluded that "a stronger focus on source countries was necessary." Accordingly, the NSC "determined that a controlled shift in emphasis was required -- a shift away from past efforts that focused primarily on interdiction in the transit zones to new efforts that focus on interdiction in and around source countries." n128

[*375] Following this 1993 NSC recommendation on national drug policy, President Clinton issued Presidential Decision Directive 14 (PDD-14), n129 which called for (1) "providing assistance to those nations that show the politi-

cal will to combat narco-trafficking through institution building," (2) "conducting efforts to destroy narco-trafficking organizations," and (3) "interdicting narcotics trafficking in both source countries and transit zones," through a controlled shift of resources from the transit zones, like the Caribbean and Mexico, to the source countries, like Colombia, Bolivia, and Peru. n130

Ironically, in view of the deep transit zone interdiction cuts proposed and effectuated by President Clinton in 1993, 1994 and 1995, the 1995 Strategy boldly states, "Without effective transit zone programs in place, the smooth implementation of the new source country program will be severely inhibited . . . ." n131

Putting aside their strategic advisability and impact on interdiction zone programs, the programs have been both poorly funded and intermittently mismanaged. Testimony by a GAO official in June 1995 raises serious concerns about the adequacy of both funding and consistent management of these vital programs. The GAO official reported, for example, that problems have periodically arisen as to who was "in charge of anti-drug activities in the cocaine source countries." n132 GAO was also concerned after receiving the impression that "the Drug Enforcement Administration is reducing its presence in Colombia, [and] the U.S. Southern Command is now flying fewer sorties per month in support of source-country interdiction than it did in 1993." n133 Additionally, an absence of consistent funding contributed to an impression that funds in source countries "are not always well managed," n134 and, most disturbingly, that "$ 45 million originally intended for counter narcotics assistance to the cocaine source countries was reprogrammed to assist Haiti's democratic transition." n135 In short, more consistent funding and [*376] better regional coordination are advised, although not at the expense of transit-zone interdiction.

c. *Inter-agency coordination for supply-reduction needed.* Supply-reduction efforts appear to have been hampered by occasional lack of inter-agency coordination. Based on in-country interviews done in early 1995, the GAO concluded that: (1) "better leadership was needed to integrate all U.S. programs in the region to develop a coherent plan[;]" (2) the "lack of coordination and clear statements of responsibilities [among various agencies] has led to confusion over the role of the offices responsible for intelligence analysis and related operational plans for interdiction[;]" (3) the "specific roles and authorities" of the Interdiction Coordinator "were not established" despite the USIC's responsibility for coordinating interdiction; n136 (4) the Interdiction Coordinator's "ability to coordinate [inter-agency] activities was limited because of the lack of funds, expertise, and authority over agencies" responsible for interdiction; n137 and (5) the socalled "interagency working group on international counternarcotics policy," which is "responsible for developing and ensuring implementation of an international counternarcotics policy" and chaired by the Department of State, needs further evaluation. n138

In general, GAO confirmed the need for tighter control of inter-agency activities, better regional coordination, stronger presidential leadership supporting an individual placed "in charge" of coordinating supply-reduction, and clearer lines of authority.

Another GAO study found that, back in Washington, better coordination between agencies is imperative. This lack of coordination has, for example, required the ONDCP to use its budget certification authority to force changes in agencies' budgets. As a last resort, "ONDCP has used its budget certification authority to increase several agencies' drug budgets [within the constraints of that agency's overall budget] by threatening decertification and has decertified two agencies' drug budgets that, according to ONDCP, were not adequate to implement the objectives . . . ." n139 This type of budget leverage requires strong presidential backing of ONDCP vis-a-vis the errant agency and the Office of Management [*377] and Budget; absent such strong backing, ONDCP's position is marginalized.

The Department of Defense's submission of its annual drug budget is illustrative of the overall problem. As the GAO reported in 1993, while DoD submits its budget for drug interdiction to the ONDCP in accordance with the 1988 Anti-Drug Abuse Act, DoD's drug-interdiction budget is not typically broken down by specific agencies and components, unlike other federal departments with drug control responsibilities. n140 Generally, DoD agencies do not submit agency-specific drug budgets to ONDCP until August, much later than the May submissions of other agencies, "leaving ONDCP little opportunity to recommend changes affecting [DoD] budget priorities and resources" and forcing ONDCP "to make rushed reviews of DoD's drug budgets." n141

The theme that runs through every serious inquiry or investigation into supply-side coordination is that leadership must be from the top-down, strong, consistent and accompanied by a clear chain of command that begins with the President.

This need for Presidential leadership was the essential finding of the unclassified portion of the "After Action Report" on the October 1994 ONDCP/SOUTHCOM Counterdrug Conference.

That report noted, among other observations, that "the counterdrug strategy must be led from the top down" and that leaders must "establish an interagency process to review and terminate ineffective programs early," "review the lead agency concept and determine which organization is best suited to plan, resource and execute national drug control policy," "acquire support from the senior levels of leadership in the Administration, starting with the President," "develop broad policy guidance for interagency regional implementation plans," "identify a regional planning coordinator and mandate the terms of reference for source country strategy implementation," and "create a streamlined regional mechanism for planning and executing the strategy." n142

[*378] The report offered a host of suggestions for improved supplyreduction coordination. However, while awareness of the need for increased coordination is promising, there is reason to believe that follow-through has been -- if 1995 testimony by Dr. Lee Brown is any indication -- weak. One reason for this distance between recommendation and action, ironically, may be the difficulties inherent in inter-agency coordination.

On the positive side, a model for more effective coordination may lie in the recently conceived joint interagency task force concept, a limited but important creation of PDD-14. Under the JIATF concept, agencies pool resources and personnel in one location for a defined purpose (e.g., intelligence collection and sorting) and coordinate with outlying agency arms for more effective follow-through (e.g., detection, monitoring and trafficker apprehension). Joint Inter-Agency Task Force-East (JIATF-East) is one example of this concept in practice. n143 While JIATF-East [*379] represents a meaningful step in the right direction -- and is presently headed by a two-star U.S. Coast Guard admiral -- interagency coordination remains a major barrier to more effective implementation of the National Drug Control Strategy.

d. *Low national security priority given to counternarcotics effort.* Another overarching concern is the National Security Council's seeming disinterest in drug policy, PDD-14 notwithstanding. Interdiction efforts may have been hampered, both directly and indirectly, by the reported low national security priority placed on the Drug War by the Clinton Administration.

Public reports suggest that the counternarcotics effort has been placed at priority "Number 29" on a White House list of national security priorities. According to one account, "the White House National Security Council has dropped the drug war from one of three top priorities to No. 29 on a list of 29, according to several sources." n144 There is no indication that the priority has ever been elevated, even informally, since February 1993. In fact, ONDCP's seemingly dismissive response to Admiral Kramek's letter of December 1994 urging reassessment of the "national security" threat corroborates the low priority ranking. n145

e. *Low priority on USIC and ONDCP staff.* Additionally, the man in charge of the nation's interdiction effort has been given only six persons to administer all United States interdiction policy. Admiral Kramek also testified that he briefs ONDCP Director Brown only monthly. n146

Notably, the President has also allowed ONDCP to remain without a Deputy for Supply Reduction, an unprecedented act, which appears to buttress claims of White House indifference.

The low priority of the drug war with the current administration also appears to be confirmed by the President's sudden 1993 cut in ONDCP staff by more than eighty percent; overnight, the ONDCP staff dropped from 146 staff to 25, with a simultaneous reduction in the FY 1994 ONDCP appropriations from $ 101.2 million [*380] to $ 5.8 million. Expert witnesses hold that these actions contributed to the perception that the Administration placed a low priority on anti-drug efforts, and to the reality that ONDCP has been unable to perform previous functions, especially on interdiction policy. n147

f. *Legal constraints on policy.* Beyond the loss of assets, the Nation's transit-zone interdiction effort operates under other constraints. Cuban territorial waters, for example, present an obstacle to effective Caribbean interdiction since they offer legal shelter to traffickers; run-and-duck tactics were, for example, used extensively by traffickers in early February 1995.

The inability ofU.S. aircraft to overfly Cuba is a continuing barrier to effective air interdiction. Traffickers can overfly the island at altitudes that radar is unable to track, and can easily blend with ground cover. This tactic has been used recently by aircraft originating in Jamaica and the West Caribbean.

Finally, the large number of sovereign nations in the region, and the importance of being able to pursue traffickers into these waters for purposes of apprehension, indicates a strong need for more bilateral agreements to facilitate drug trafficker apprehension and joint operations in foreign waters. n148

g. *Reduced emphasis on drug-related law enforcement.* From both a budgetary and prosecutorial perspective, drug-related law enforcement has suffered a setback since 1993. The Administration's FY 1995 budget advanced cuts of 621 drug enforcement personnel from DEA, FBI, INS, U.S. Customs and the U.S. Coast Guard; although Congress restored these proposed White House cuts, DEA has lost approximately 227 special agent positions between 1992 and 1995. n149 These losses are corroborated by field agents who describe their jobs as increasingly difficult in the absence of trained personnel. n150

[*381] Moreover, there is a close correlation between the Administration's cuts in drug-related law enforcement and declining drugrelated prosecutions between 1992 and 1994. Specifically, the reported number of drug violations dropped from 25,033 in 1992 to 23,114 in 1994, or twelve percent in only two years. n151

h. *Implications of degraded interdiction policy.* Based on the relationship between the rollback of interdiction and the rise of juvenile drug use and crime, the main implications of reduced interdiction over the past three years, combined with other factors, have been: (1) lower street prices for cocaine, heroin, and marijuana, (2) higher availability of these drugs, (3) higher purity levels for these drugs, (4) higher casual drug use by juveniles, (5) greater juvenile addiction, (6) rising drug-related juvenile crime, (7) increasing drug-related medical emergencies, and (8) a growing international perception of reduced U.S. commitment to the Drug War. n152

B. *Demand-Reduction Policy and Programs*

The 1995 National Drug Control Strategy counseled, and became the touchstone for, a shift away from transit-zone interdiction [*382] programs. While many of these resources failed to appear in the source countries, they plainly disappeared from the transit zone. However, another measure of the Clinton strategy is the demand-side shift toward emphasis on drug treatment for chronic drug addicts, at the expense of attention to preventing casual use by juveniles, the obvious foundation upon which hardcore use rests.

1. Drug Prevention Programs Praised

Just as prevention experts acknowledge the importance of law enforcement and interdiction, interdiction and law enforcement experts increasingly recognize the central role that must be played by parental, community, state and federal drug prevention efforts if the resurgence of drug use among the nation's youth is to be reversed. n153

Accountability, in the context of federal drug prevention programs, has two components. First, although programs built around a strong "no-use" message delivered through schools and community programs are to be applauded, reported allegations of missing financial audits and the non- "no use" content of some federally funded curricula gives rise to questions about what SDFS funds, for example, are actually expended on, by whom, and under whose supervision within the Federal Government.

Apparently, most interdiction and law enforcement experts, including Walters, Yost, Bennett, and Bonner, seem to agree that prevention was central to the success of counternarcotics programs in the 1980s. They also readily concede the need for including parental, local, state and federal prevention efforts in the total mix.

After testifying on interdiction and law enforcement, former Drug Czar Bennett noted, for example, that "success in the drug war depends above all on the efforts of parents and schools and churches and police chiefs and judges and community leaders," citing examples from his visits to more than 100 cities as Drug Czar during the Bush administration. n154

Admiral Yost emphasized that interdiction alone will not win the drug war, and that interdiction is just the foundation for [*383] effective prevention, education and treatment -- and "that's what will win the war." n155

Other experts confirm this view. Thomas Hedrick, Jr., Vice Chairman of the Partnership for a Drug-Free America, testified that prevention and interdiction advocates must begin to work together, and that "preventing drug use by young people" is essential "if we are to have a prayer of building safe and healthy families and communities." At the federal level, Hedrick expressed the view that "Federal support and Federal leadership in making drugs a critical national priority is essential, if we are to help convince the media that this is an important issue." National leaders, Hedrick stated, must also tell those community leaders involved in this fight that what they are doing is important. n156

In 1995 congressional hearings, Hedrick's view was shared by Bridget Ryan, Executive Director of the BEST Foundation for a Drug-Free Tomorrow. Ryan testified that a recent RAND study advocated drug prevention as the "first priority" in curbing drug abuse, noting the distinction between "validated" and "unvalidated" drug prevention programs. Ryan also urged that the former be adequately funded. n157

According to Ryan, who described herself as "on the front lines of the implementation process," "prevention can and does work, but our educators and policy makers must be selective in funding and implementing validated programs." Ryan noted that an estimated 2000 non-validated programs are in use. n158 Another expert voice from within the prevention community, James Copple, National Director of the Community Anti-Drug Coalitions of America ("CADCA") -- a privately funded organization representing approximately 2500 community coalitions nationwide -- testified that "CADCA members have been more than a little frustrated with the failure of the nation's leadership to keep the pervasiveness of drug abuse before the American people," since this is part of the prevention effort. Referring to the 1995 White House ONDCP Strategy, Copple testified that "a strategy . . . is only as good as the resources that follow it and the visible leadership that advances it." More directly, he held that "there [*384] must be a national voice advocating for substance abuse prevention, and that voice should be loudest from the White House and the Congress." n159

Perhaps the most moving and persuasive testimony of the 1995 hearings was delivered by former First Lady Nancy Reagan. Reagan, long a leader in this prevention effort, warned the Nation not to abandon the children affected by indifference to the Drug War.

She opened her testimony with echoes from a different policy period, noting that she had "decided to speak [before Congress on the drug issue] only after a lot of soul searching . . . because my husband and everything he stands for calls for me to be here." n160

She then explained her worry that the nation "is forgetting how endangered our children are by drugs," that societal "tolerance for drugs" is up, and that "the psychological momentum we had against drug use [in previous years] has been lost." In short, she asked, "How could we have forgotten so quickly?" n161

She warned that constant vigilance and attention to drug prevention is the only way to avert the "tragic human consequences" of surrendering our children to these narcotics, illustrating her point with a letter from a 16-year-old girl, which described the misery left in the wake of drug use and gradual dependence. n162

Directing herself to national policy, Reagan quoted from President Clinton's 1995 National Drug Control Strategy, which states that "'anti-drug messages have lost their potency.'" Mrs. Reagan countered: "That's not my experience. If there's a clear and forceful no use message coming from strong, outspoken [*385] leadership, it is potent . . . . Half-hearted commitment doesn't work. This drift, this complacency, is what led me to accept your invitation to be in Washington today . . . . We have lost a sense of priority on this problem, we have lost all sense of national urgency and leadership." n163

She stated that while treatment is important in the overall mix of anti-drug measures, it cannot supplant prevention as the nation's priority. Reagan noted that, "treatment can't begin to replace the overwhelming importance of education and prevention," since "tomorrow's hardcore users are today's children." n164

2. A Closer Look at Prevention Accountability

Despite strong bipartisan support for "validated" and accountable prevention programs, there appears to be cause for concern, namely that certain drug prevention programs are neither validated nor accountable. Indeed, allegations have recently arisen indicating a potentially systemic accountability problem in at least one major federal prevention program.

Returning to expert testimony from prevention program administrator Bridget Ryan, of the BEST Foundation for a Drug-Free Tomorrow, added that "prevention can and does work," but "our educators and policy makers must be selective in funding and implementing validated programs." From within the field, Ryan testified that, "it is estimated that more than 2,000 non-validated programs are in use," and surprisingly urged Congress to insist that federal funding flow only to validated programs. n165

In addition to this general recommendation, the hearings brought to light another disturbing and largely unnoticed policy flaw. Expert testimony and documentary evidence was offered suggesting that the Safe and Drug Free Schools ("SDFS") program, [*386] which provides seed money for some of the most effective drug prevention programs, has also reportedly been subject to serious misuse, waste and abuse of funding. At present, in the absence of more probing investigations, no conclusion can be reached as to the veracity of these allegations. On the other hand, they remain serious, and appear to be corroborated by documentation from various states.

The accountability issue was effectively raised by Representative Ileana Ros-Lehtinen (R-Fla.) in the early 1995 hearings. She articulated her reservations carefully, in questioning of then-White House Drug Czar Lee Brown: "There

is a growing concern that federal prevention monies have not only been wasted, mismanaged and been ineffective but . . . have been spent on educational programs which teach value relativity and fail to teach that illegal drug use is wrong -- just plain and simple wrong." n166

Representative Ros-Lehtinen identified specific problem programs, and sought an explanation from then-ONDCP Director Brown for federal financing of so-called "values clarification" curricula, including "Quest," "Here's Looking At You Too," and other programs that she questioned may not deliver a no-use message.

Unfortunately, while Dr. Brown acknowledged the potential for abuse n167 and disagreed with any program not teaching no-use, he offered no proposals for heightened accountability. When asked what he would do about the reported SDFS abuses in Michigan, Massachusetts, Texas, Washington State, Kansas, Indiana, and West Virginia, n168 the former ONDCP Director responded that "the Department of Education administers the Safe and Drug Free Schools Program . . . [and] we . . . have been working with [them] in looking at how do you set up standards for addressing the problem." n169 Brown added that the Education Department was working "to alleviate and hopefully eliminate all the abuses in the program that take place." n170 He testified that he "would be the first to admit that there are abuses of the [Safe and Drug Free Schools] program." n171

[*387] A series of letters confirming these concerns from around the nation was introduced at that congressional hearing, along with a study released by the Michigan State Office of Drug Control Policy documenting abuses in that state of the Safe and Drug Free Schools monies. n172

Making clear that she favored accountable prevention programs, Ros-Lehtinen introduced evidence that

> in Michigan, more than $ 10 million in Federal funds intended to provide our children a front line defense against drugs was utilized for the following: Over $ 81,900 for large teeth and giant toothbrushes; over $ 1.5 million on a human torso model used in one lesson of one grade, not even in the drug section of the curriculum; wooden cars with ping pong balls, over $ 12,300; hokey pokey song, over $ 18,000; over $ 7,000 on sheep eyes, whatever that is; dog bone kits, $ 3,700; bicycle pumps, $ 11,000; latex gloves, $ 12,000; over $ 300,000 was spent on how we feel about sound. n173

Representative Ros-Lehtinen concluded with another constituent complaint, quoting: "These nondirective programs are often funded through Federal Drug Free School grants, yet they do not usually comply with Federal law requiring that students be taught that drug use is wrong and harmful." n174

Additionally, a July 15, 1994, letter from Dr. Brown to the Assistant Secretary of the Office of Elementary and Secondary Education concerning the Safe and Drug Free Schools Program was introduced into the record at public hearings on April 6, 1995. Congresswoman Ros-Lehtinen read the letter aloud and reminded Dr. Brown that, "you, yourself, pointed out seven accountability issues" in this letter, adding "I believe that it's hypocritical -- excuse me, sir -- but for you to attack some of us who are pointing out the ineffectiveness of the programs when you saw and wrote on it yourself." n175

On balance, expert opinion appears divided between those who favored 1995 cuts based on reported abuse, and those who did not favor such cuts; the pivotal question was whether to fund programs that are successful in some locations, but also have [*388] accountability problems. These programmatic concerns, however, did not alter the general support of Committee members for heightened prevention efforts.

3. No Prevention Leadership from the "Bully Pulpit"

One aspect of prevention atthe federal level involves the President using the "bully pulpit." n176 "In conjunction with the importance of national leadership," Bonner explained, "is the importance of a clear, coherent and simple message from the President." n177 "The message should emphatically imbue our youth with the moral understanding that the use of illegal drugs is wrong," Bonner continued. "Messages not only matter; they are critical to curbing drug use among children. Reagan's 'Just Say No' program played a crucial role in affecting the attitudinal changes necessary to achieve the Reagan-Bush successes. We need that moral message if our national strategy is to prevail in the minds of our youth." n178

From 1993 through 1995, President Clinton rarely spoke about the need for either demand-side reduction of illegal drug use or supply-side measures to stem international narcotics trafficking. n179 Indicating precisely the paucity of presidential reference to the drug issue, Representative Zeliff stated:

> In 1993, President Clinton made seven addresses to the nation; drugs were mentioned in none. His presidential papers reveal only thirteen references to illegal drugs in a total of 1,628 statements, addresses, and interviews. During 1994, presidential leadership was little better -- of 1,742 presidential statements, only 11 contained any mention of illegal drugs. n180

[*389] 4. Treatment Programs Face Concerns over Effectiveness and Accountability

Drug treatment, despite facing serious criticism about effectiveness and accountability, remains an important part of any balanced national drug policy. President Clinton's former White House Drug Czar, Dr. Lee P. Brown, asserted in early 1995 hearings that "past strategies ignore [drug treatment as an] inextricable part of the drug problem." n181 In fact, federal funding for treatment has increased every year from 1982 through 1995. n182

a. *Treatment effectiveness challenged.* Progress has been made in developing a range of drug treatment approaches during the past decade. However, significant doubt remains about the effectiveness of drug treatment generally, and about the accountability of federal drug treatment programs in particular. To date, there is too little reliable research.

On March 9, 1995, former DEA Administrator and federal Judge Robert Bonner testified that "the Clinton strategy badly oversells the efficacy of the treatment of hard-core drug abusers" and fails to acknowledge that "studies repeatedly indicate the low success rates associated with many programs." n183 Bonner cited the work of Harvard University's Mark Kleiman, a former member of the Clinton Justice Department transition team. Kleiman's work shows that "even the most expensive treatment program -- long-term residential treatment programs costing as much as $ 20,000/patient -- have success rates as low as 15 to 25 percent." n184 Judge Bonner also explained that "with respect to crack addicts . . . after treatment programs, less than 10 percent are free of drugs, free of crack, after 24 weeks, so you don't want to put too many eggs in that [treatment] basket." n185 Other drug [*390] treatment studies and testimony explain why drug treatment programs have been unable to register better results. n186

Injecting added concern, John Walters, former Acting Director of ONDCP, testified that the Clinton Administration has failed to create the number of treatment "slots" necessary to accommodate its own stated treatment priority. Walters stated that "although federal drug treatment spending almost tripled between FY 1988 and FY 1994, the number of treatment slots remained virtually unchanged and the estimated number of persons treated declined -- from 1,557,000 in 1989 to 1,412,000 in 1994." n187

A reduction in the number of hard-core addicts might constitute one measure of the current strategy's success. However, arguments that hardcore use has been reduced through emphasis on treatment are belied by recent Drug Abuse Warning Network ("DAWN") data. The latest DAWN data shows that "drug-related emergency room cases . . . have reached the highest levels ever, in reporting going back to 1978[,]" and "cocaine, heroin, and marijuana cases all increased sharply to record levels [in 1994]." n188 And Walters noted that the current strategy failed to reduce the number of chronic, hardcore drug user numbers -- that number is actually rising. n189

b. *Treatment accountability challenged.* Failure of the current strategy to generate even a small reduction in hard-core addiction is partly attributable to the "government's treatment bureaucracy[,]" which some experts see as "manifestly ineffective." n190 Addressing accountability, Walters testified that "some of those programs are simply not effective, but there are insufficient structures monitoring performance to force them out of business . . . . Federal measures for accountability and targeting must . . . reach through multiple layers of bureaucracy -- in the federal government, and in state and local governments." n191 Thus, the [*391] best treatment programs may be placed at a disadvantage by an inability to weed the good programs from the poor ones.

c. *RAND treatment study of limited value.* In striking contrast to these expert assessments, Drug Czar Lee Brown had urged increased emphasis on drug treatment. To defend this strategic shift, Brown and the White House relied heavily on a June 1994 RAND study ("RAND study") that favors treatment over other use reduction options. n192

According to Brown, the RAND study found that "drug treatment is the most cost-effective drug control intervention[,]" and that "for every dollar invested in drug treatment in 1992, taxpayers saved $ 7 in crime and health care costs." n193 This study formed the empirical centerpiece of Brown's 1995 request for $ 2.8 billion for treatment.

n194 Closer examination of the study, however, suggests that the heavy reliance on it by the White House is questionable. The RAND study has clear limitations, operates from assumptions few drug policy experts would accept, and is easily misread.

Of clear value, and not otherwise affected by subsequent criticisms, are two key findings. First, the study appropriately condemned drug legalization. n195 Second, it implicitly condemned the Administration's "controlled shift" of resources from interdiction to source country programs.

On the "controlled shift" issue, RAND concluded that interdiction is more effective, dollar-for-dollar, than pumping money into source country programs. Ironically, the Administration embraced the study's pro-treatment conclusions, and yet rejected this anti-source country program conclusion. As one drug policy expert, who is favorably disposed to the pro-treatment finding conceded, "This analysis implies that the National Drug Control [*392] Strategy's 'controlled shift' of resources from interdiction to source-country control might be a misstep." n196

The most glaring methodological omission revolves around the study's failure to discuss prevention programs: it simply does not account for prevention as a viable means for reducing demand for cocaine. This constitutes a serious oversight, since prevention is widely recognized as a central and effective means for demand reduction. n197 President Clinton's reliance on the RAND study, which promotes treatment at the expense of prevention, reflects a marginalization of prevention strategy.

The President's 1995 strategy is rhetorically consistent with the RAND study's omission of prevention because the strategy assumes that "anti-drug messages are losing their potency among the Nation's youth." n198

A second serious limitation is RAND's failure to follow users for a meaningful period of time following active treatment. Instead, the study was able to conclude only that cocaine consumption falls during residential and out-patient treatment.

In another admission, the study acknowledged that once treatment ends, only about twelve percent of out-patient and seventeen percent of residential treatment recipients stop heavy use of cocaine. n199 Certainly a national drug policy centered on twelve to seventeen percent reductions in the smaller of the two user populations (i.e., the twenty percent of users who are hardcore users rather than the eighty percent who are casual users) reflects poor judgment.

Fourth, RAND favored treatment chiefly because that approach has a "direct" impact on users. This minimizes supply-side programs (e.g., interdiction, source country, domestic law enforcement), which affect a larger number of users but have only an "indirect" impact. The RAND study acknowledged, however, that higher street prices, resulting from interdiction, source country programs, and domestic law enforcement, reduce consumption.

Finally, the RAND study employed a measure of effectiveness that arguably is flawed. The study did not measure effectiveness by reduction in cocaine users, but rather by reduction in the overall amount of cocaine consumed in the United States. Because [*393] the study found that hardcore users consume, on average, eight times the cocaine that casual users do, RAND found that treatment was the appropriate response.

However, the RAND study's measurement for effectiveness is misguided; it fails to take into account that societal drug use is dynamic, not static. While current cocaine users might respond positively to treatment, the total user population will continue to accelerate as the number of casual users climbs and many of these become hardcore addicts themselves. Unless the number of casual users switching to hardcore users is smaller than the number of hardcore users successfully treated, the treatment approach amounts to a losing prospect.

In fact, casual use is now rapidly growing, n200 and with it the number of hardcore users, n201 even assuming RAND's finding that between twelve and seventeen percent of the current hardcore user population is being treated successfully. n202 Thus, if the aim of national drug control policy is to reduce the number of users (not the amount of cocaine imported as RAND suggests), any strategy favoring treatment over effective prevention will be selfdefeating.

Moreover, most conservative extrapolations of the number of casual users that become hardcore addicts, for example those given by former Carter Cabinet Member Joseph Califano, indicate that such a strategy will lead to a nation awash in young cocaine addicts. Califano's Center on Addiction and Substance Abuse ("CASA") at Columbia University recently concluded that, "if historical trends continue, the jump in marijuana use among America's children (age 12-18) from 1992 to 1994 signals that 820,000 more of these children will try cocaine in their lifetime . . . . Of that number, about 58,000 will become regular cocaine users and addicts." n203

5. Poor Demand Reduction Interagency Coordination

Even more than supply-reduction coordination, inter-agency coordination of demand-reduction programs is in need of serious [*394] rethinking. Neither better prevention accountability nor enhanced treatment effectiveness will address the lingering potential for waste and mistargeting that results from poor demand-side interagency coordination.

ONDCP is charged with coordination of federal demand- and supply-side reduction efforts. n204 In fact, however, ONDCP seems to have too little budget authority, n205 too little support from the President when confronting agency intransigence, n206 and is dependent on non-institutional factors in achieving even the current level of coordination. n207

In September 1993, the GAO reported that "ONDCP and HHS had major disagreements over the collection and reporting of drug data," that an internal HHS memorandum asserted that [*395] there was a "serious [inter-agency] problem . . . in trying to implement new drug abuse programs [while complying with ONDCP oversight]," that ONDCP's ability to secure "implementation plans" from the agencies for 400 objectives in the drug strategy was being resisted, and that the Departments of Education, HHS, and Justice seemed unable to cooperate with ONDCP. n208

Notably, however, GAO reported that "the lessening of friction between ONDCP and federal drug control agencies should not be brought about through elimination of ONDCP's oversight responsibilities." n209 Nevertheless, these conclusions provide a persuasive argument for rethinking the way in which coordination of demand-reduction is handled. Several competing ideas are now under discussion. n210

III. REACHING BASIC CONCLUSIONS AND CREATING THE BLUEPRINT FOR AN EFFECTIVE NATIONAL DRUG CONTROL POLICY

A. *Reaching Basic Conclusions*

The Nation's political leadership appears to have badly misjudged the resilience of the drug abuse epidemic, particularly among America's youth. At the same time, the President's National Drug Control Strategies from 1993 to 1996 have also underestimated the enormity of the national security threat posed by spreading international drug cartels in Colombia and Mexico and international drug trafficking, chiefly from Peru, Bolivia, and Colombia, through Mexico and the Caribbean, to the United States. One reason underlying these twin misjudgments may be a simple delay in recognizing the link between a policy of disinterest [*396] in casual use and the steady rise in both juvenile addiction and violent juvenile crime.

On the other hand, important members of the Administration, including the President's Interdiction Coordinator, and current and former Administrators of his Drug Enforcement Administration, have been vocal about the growing national security threat posed by surging illegal drug use and the international drug cartels. Unfortunately, their voices have been lost in the din of Administration rhetoric.

As the annual release of new drug-use statistics approaches in late 1996, voices advocating serious drug policy rethinking, including redesign and implementation improvement, can no longer be ignored. In fact, the rapid resurgence of juvenile drug use and violent crime, coupled with the growing influence of drug traffickers in both Mexico and Columbia, requires a new commitment to cooperation both from those who have historically favored supply-side efforts and those who have, instead, preferred to conceive of the challenge as chiefly demand reduction.

In general, those who support increased funding and development of prevention or treatment programs, to the exclusion of greater supply reduction efforts, can no longer afford to miss the incontrovertible A-B-C-D connection between (A) supply reduction efforts, (B) street price, street purity, and street availability, (C) casual drug use, and (D) hardcore or addictive drug use, which often ends (either directly or indirectly) in disease, injury, or death. Since violent crime appears to rise with both casual and addictive use, the need for effective supply reduction is compelling. Without it, prevention efforts will be unavailing and treatment programs will be awash in young addicts.

On the other hand, it is also clear that those who support increased funding and development of transit-zone interdiction, source country programs and law enforcement, to the exclusion of greater prevention and research into treatment, can not afford to miss the A-B-C-D connection between (A) increased prevention, (B) decreased casual use, (C) decreased addiction, and (D) decreased disease, death, and violent crime (since both casual and addictive use directly impact violent crime). Without effective and accountable prevention, as well as some hope for progress in treating those whom prevention misses, violent crime will rise, as will nationwide demand, compounding the problems currently facing both interdiction and law enforcement.

[*397] Finally, the current crisis should send a shock wave through both the demand and supply reduction communities, notonly bringing those communities closer to one another, but making clear that tensions within both communities must dissipate if an effective National Drug Control Policy is to emerge and work. The communities must become better at communicating one, cohesive message to national leaders.

Ultimately, this message must be based on the existing body of empirical evidence, not wishful thinking. There is every reason to believe that major victories can be scored in a well-designed, well-coordinated, and widely supported drug war. However, in setting the course for success, there is no room for apologies. Ineffective, unaccountable, and poorly implemented federal programming should be fixed or scrapped. If preserved, these programs should fit within the overall thrust of the redesigned policy.

In short, we must take stock of how far off track we have gotten, and then design, implement, and adequately fund a comprehensive National Drug Control Policy that will get the Nation back on track.

B. *Specific Conclusions on Interdiction, Source Country Programs, Prevention, and Treatment*

Despite an expert consensus that interdiction is vital, President Clinton proposed and executed a downgrading of interdiction within the National Drug Control Strategy. He has proposed and supported interdiction budget cuts in 1993, 1994, 1995, and 1996. For FY 1997, while President Clinton has increased interdiction slightly, from $ 1.33 billion in FY 1996 to $ 1.43 billion in FY 1997, this number is still far below the effective effort in FY 1993, which was $ 1.511 billion. Moreover, it is far less than the $ 129 million increase in drug treatment funding, which elevates drug treatment part's of the budget from $ 2.862 billion to $ 2.908 billion.

Overall federal support for transit-zone interdiction, as measured by these budget numbers and other factors, reveal a shrinking Administration commitment to drug interdiction. The other factors include the National Drug Control Strategy's express shift to drug treatment, retirement and redeployment of selected drug interdiction assets to non-drug related missions, failure to [*398] fill the ONDCP position of Deputy Director for Supply Reduction, reduction of the U.S. Interdiction Coordinator's staff to six, White House disinterest in the December 1994 "agency head consensus" favoring increased interdiction support and coordination, diminished rhetorical support from the President, and a reduced national security rank for the Drug War. Strategically, despite the success of interdiction techniques used in the late 1980s and early 1990s, such as "pulsing" of resources in the Caribbean by former U.S. Coast Guard Commandant Paul Yost, the Administration has clearly abandoned the earlier transit-zone strategy.

With respect to the source country programs, in theory, the National Drug Control Strategy was to usher in a "controlled shift" of resources to Columbia, Bolivia and Peru; n211 in practice, while resources have been taken from transit-zone drug interdiction, they have not reappeared in the source country programs. This has meant that "disruption rates" in the interdiction zone are down, n212 and yet the "controlled shift" has not been implemented. n213

Beyond this, in June 1995, the General Accounting Office conducted a comprehensive, in-country investigation of the source country programs and found that no one was "in charge of anti-drug activities in the cocaine source countries" and that there was a "lack of coordination." n214

Moreover, GAO's investigation also found that "$ 45 million originally intended for counter-narcotics assistance to the cocaine source countries were reprogrammed to assist Haiti's democratic transition," and despite a November 1993 promise that he would "develop a separate strategy to combat the heroin trade" within 120 days, President Clinton had not developed or signed any heroin strategy as of June 1995. n215 These findings suggest a [*399] need for greater source country coordination, funding and consistency.

Turning to prevention policy, experts seem to coalesce around the view that prevention is the foundation of demand reduction, particularly for America's youth. Even among treatment advocates there appears to be growing awareness that prevention must succeed if treatment programs are not to be overrun. Moreover, there is a consensus that prevention should be a priority for national leaders of both major parties, including individual members of state legislatures and Congress, governors, mayors, and the President.

Accordingly, there is understandable support for the Department of Education's Safe and Drug Free Schools program, and it is acknowledged to have resulted in seed money for local program successes. On the other hand, serious accountability problems remain, and there is a clear need for greater financial accountability and program validation.

With the aim of program improvement, not program elimination, a serious program-by-program review must be undertaken at the Departments of Education, HHS and Justice, and program accountability mechanisms should be inserted in the governing statutes and departmental regulations. Existing accountability regulations must also be enforced.

Finally, while most agree that treatment is part of any effective use-reduction strategy, there is evidence that many existing public programs are ineffective or poorly monitored, and thus difficult to defend objectively. The much-touted June 1994 RAND study supporting treatment appears to be of limited utility, since it omits prevention from the demand-reduction mix, and suffers methodological flaws that compromise chief findings.

Empirically, the Administration's shift to treatment of older, chronic, hardcore addicts has not reduced the number of hardcore addicts. In fact, it may have increased the number of existing and future addicts, by failing to create ample treatment slots, overselling treatment's efficacy, and allowing the number of casual users to rise. There is little room for de-coupling from treatment the opportunity cost it has occasioned, namely a reduced emphasis on casual and juvenile drug use and the corresponding increase in both, along with juvenile crime. n216

[*400] The gravamen is this: while research into identifying effective treatment methods (including chemical approaches) should remain part of the overall strategy, federal funding must be targeted at (A) proven and effective programs (often located in correctional institutions) or (B) basic treatment research. Funding for general treatment programs with no proven track record, or a record of low effectiveness, should be avoided.

Second, treatment should not have been disproportionately funded, as it has been in 1993, 1994, 1995 and 1996. That shift within the demand reduction mix has had the effect of reducing the federal emphasis on prevention. Since eighty percent of drug use is casual use by youth, the strategy should be directed at this at-risk population. There must be a recognition that reducing use among this population will ultimately reduce the addict population.

C. *Blueprint for an Effective National Drug Control Policy*

1. Overview

The blueprint for an effective National Drug Control Strategy necessarily includes rethinking on many levels. There must be a basic re-focusing of the Strategy on transit-zone interdiction and nationwide prevention, rather than the recent shifts to unproven treatment. Source country programs must also be better coordinated, better funded, and more consistent (although there has been a marked improvement in coordination since the middle of 1995 and programs are operating more effectively, albeit on a shoestring budget, in 1996).

There must be rethinking about the basic design of each component of the drug war, including transit-zone interdiction, prevention and education, source country programs, law enforcement and drug treatment. Why not return to "pulsing" of interdiction resources or not? Why can not re-establish key intelligence resources for better use of Coast Guard, DEA, Customs, DoD, and State Department interdiction assets? Why not increase joint interagency task forces and restore lost detection and monitoring assets? How do we raise media involvement in prevention, following [*401] the example of groups like The Partnership for a Drug Free America, and encourage better prevention in schools, communities and families?

How can we elevate the drug issue to its rightful place as the number one national security priority? How do we enhance drugrelated law enforcement? Why not insist on full accountability in all federal programming? How do we stop funding low success-rate treatment programs, and start financing research into improved treatment methods? These and questions like them now confront those who want to tie together the disparate strands of our federal counternarcotics effort.

Coordination is the next big obstacle. Are there common sense ways to enhance interagency and interjurisdictional coordination? To improve resource management and increase the Nation's "bang for the buck?" How can these efforts be institutionalized, and how do we change our national complacency on the drug war? If it is really a national security threat, why not pattern our response on fighting a foreign adversary? What tools does law enforcement need, and what incentives can be created for better coordination between federal, state, and local law enforcement agencies? If the effort is reorganized and a hierarchy established for greater effectiveness, who should be placed "in charge?" What must a President do to support this hierarchy and generate lasting results? These are some of the main questions that confront anyone who studies the Nation's counternarcotics effort.

2. Strategic Changes

The current juvenile youth use and drug-related crime crisis, as well as the historical example set by drug strategies in the late 1980s and early 1990s, compel strategic rethinking. We need a better overall strategy, better use of existing federal resources, increased funding for priority programs, better coordination, greater consistency and more conscientious oversight.

Strategic recommendations likely to reposition the United States to "win" the drug war -- that is, to permanently disrupt the flow of illegal drugs from foreign cartels and traffickers, and substantially reduce domestic demand -- are several.

First, to assure that the Drug War becomes a top national priority, the President must clearly and unequivocally inform the Office of Management and Budget ("OMB"), Congress, and the [*402] more than fifty federal agencies and departments with counternarcotics programs that this is one of his top budget and personal priorities.

In practical terms, he must signal OMB, agency heads, and Congress that counternarcotics spending is a top priority among competing agency or departmental preferences. Instead of allowing the State Department's INL Office to be cut as other offices are uncut or grow, the President should make clear that INL funding is a priority within the State Department's budget. The same signal should flash down the corridors to all federal agencies and departments.

Second, based on the foregoing evidence and analysis, the National Drug Control Strategy must favor accountable prevention over unproven treatment programs. At the heart of this change is the rise in casual use among America's youth and its link to addiction; the correlation of casual and addictive drug use with rising juvenile crime; and the low success rates associated with many publicly funded treatment programs.

Third, in concert with the foregoing, an effective strategy must embrace renewed transit-zone interdiction, adding back lost assets and making drug interdiction a priority.

This means never again diverting $ 45 million, or any number, out of transit-zone interdiction funding to a mission as unrelated and controversial as rebuilding Haiti; while no judgment is passed on the Haiti mission, vital counternarcotics funding should not have been reprogrammed.

Drug interdiction along the land bridge with Mexico must be elevated to a higher priority within the overall Treasury budget, which oversees U.S. Customs. The United States Embassy in Mexico must also rank counternarcotics its number one priority, especially in light of the growing influence of Mexico's four drug cartels.

Only by making stronger intelligence-cued transit-zone interdiction a priority again can the nation reverse the rise in illegal drug importation, high drug availability, high drug purities, and low street price.

3. Accountability Changes

To restore accountability to the federal counternarcotics effort, the President should comply with the Anti-Drug Abuse Act of 1988, and promulgate a clear set of measurable, short-term (and [*403] long-term) goals in the annual National Drug Control Strategy. Measurable goals have been sorely missed since 1992, making defense of counternarcotics spending substantially more difficult.

The National Drug Control Strategy should not be merely descriptive; it must be more than a collection of loose goals to which agencies roughly aspire. The Strategy must become the standard against which success or failure is measured. More specifically, the Strategy should be the basic document against which future funding is weighed.

To restore accountability to demand-reduction programs -- prevention and treatment -- the President and Congress must work to implement stricter accountability mechanisms. In practice, the Safe and Drug Free Schools Act should be revisited and its language tightened, if the statute has permitted misapplication of anti-drug funds; the Department of Education should become a more vigilant watchdog agency when they learn that monies are reportedly being misused. Complete record keeping and accountability should be reflexive, not a tooth-pulling effort spurred only by constant congressional inquiry. n217

Prevention programs that have no means of assuring accountability, or which cannot demonstrate achievement of any measurable goals, or which do not fund "no use" messages should be unfunded. Similarly, treatment programs unable to assure accountability and effectiveness should be not be funded.

Likewise, supply reduction programs must be held to the highest measure of accountability available. While effectiveness may be more difficult to measure on the supply side, programs that have no means for assuring accountable expenditures or which fail to meet previously established goals should be unfunded in subsequent budget cycles.

[*404] 4. Coordination Changes

First, there must be a clearly established "chain of command" on both the demand and supply reduction sides of the counternarcotics effort. Optimally, the pinnacle of these chains will be the same person, a well-supported and hand-picked White House Drug Czar. While other potentially viable options have been circulated, n218 and some less viable options, n219 the White House Drug Czar is -- institutionally -- an important foundation upon which to build.

The White House Drug Czar should be the chief voice within the Administration on whether counter-narcotics programs continue to be funded or not, and at what levels, in consultation with OMB and the appropriations committees. In all anti-drug efforts, the Drug Czar -- and not individual agency heads -- should be viewed by OMB and Congress as the primary decision-maker.

To achieve this goal, the President must be unequivocal, vocal and constant in his support of the Drug Czar, and should delegate to him or her the fullest authority possible, within the bounds of the law, on all issuesrelating to the nation's counternarcotics efforts. The President should insist that all relevant agency heads coordinate anti-drug activities directly through that person, and that all major counternarcotics decisions be approved by that person. If the Drug Czar concept is to work, in addition to the foregoing, the Drug Czar should be a member of the National Security Council, have an office in the White House, [*405] share authority with other Cabinet members to negotiate on behalf of the President with foreign countries, and have a permanent place at every Cabinet meeting. Moreover, one document should govern all counternarcotics efforts, and that document should be the National Drug Control Strategy.

The President should maximize the Drug Czar's authority by funding ONDCP back to late 1980s levels; delegating authority for counternarcotics program prioritization, in consultation with OMB, to ONDCP; giving ONDCP the authority to evaluate antidrug program effectiveness across all agencies; and giving ONDCP primary authority to offer recommendations to Congress for program continuation, enhancement, reduction or elimination. The President should also insist that all agency heads meet personally with the ONDCP Director at least quarterly, following a format similar to the never-repeated October 1994 drug interdiction agency-head conference, and the President should publicly support efforts of the White House Drug Czar and ONDCP in the media, with cabinet officials, and in periodic addresses to the nation.

To assist ONDCP, anti-drug programs that receive their justification in the annual ONDCP Drug Strategy Budget should be identified with specificity, and the fifty-plus agencies that receive funding through these programs should be required to place details of each program before the ONDCP Director well in advance of the production of succeeding annual budgets.

5. Other Leadership Changes

At the most basic level, there must be greater parental and community leadership on this issue. Strong families are central to winning the drug war, and their efforts must be supplemented by educators, corporate, church and synagogue leaders, the media, the film industry and every individual in a position of community influence.

Nationally, in an effort to demonstrate the President's consistent support for the Nation's Drug Control Strategy, the President should speak out regularly, utilizing the presidential "bully pulpit" to elevate the issue and build public support for demandand supply-reduction efforts.

To bring the issue immediately back to the forefront of the nation's agenda, the President should also address the nation from the Oval Office or address a Joint Session of Congress on [*406] the topic of exploding teenage drug use; commence a series of domestic White House Drug Policy Conferences, including one each on prevention, narcotics-related law enforcement, interdiction, source country programs, treatment programs, and the role of the media; meet personally with congressional leaders on this issue at least once or twice annually, for example, with the Bipartisan Drug Policy Group (currently co-chaired by Representative Zeliff and Representative Charles Rangel (D-N.Y.)); appoint a bipartisan White House Commission on "Winning the Drug War" to study the evolving options in depth; and convene an international "President's Summit" on counternarcotics, in a Central or South American capital, such as Lima or Mexico City. Absent national and international use of the "bully pulpit," other changes are not likely to succeed.

A number of other concrete changes could be implemented swiftly, and would markedly alter the public perception and actual effectiveness of the drug war.

Some are specific to supply reduction. Among these, the President, through National Drug Control Policy, should consider elevating the drug war threat within the National Security Council's list of national security priorities to the top position. He should also restore funding for interdiction to 1992 levels; restore funding to ONDCP lost in 1993 Administration cuts; and restore funding for intelligence lost between 1993 and 1995. Future National Drug Control Strategies must reverse the erosion in key interdiction assets.

On the personnel side, the Strategy must recognize the specialized nature, and long term utility of internationally based DEA, U.S. Coast Guard, DoD, FBI, and intelligence community personnel.

From a policy perspective, the President should also issue the missing agency Implementation Guidelines for the November 1995 Heroin Strategy; assure PDD-14 is made effective by proper funding and coordination of source country programs; and insist on accountability mechanisms in source country programs to ensure proper resource management, inter-agency coordination, clarity and targeting (specifically answering the individual concerns in the June 1994 GAO testimony).

The President must also avoid the kind of deadend streets that current policy creates; he must establish a process for direct, regular communications between the U.S. Interdiction Coordinator (USIC) and the National Security Advisor, if not also between [*407] the USIC and the President. Consideration should also be given to making the USIC operational, and reserving most counternarcotics policy to the ONDCP Director.

To strengthen the law enforcement component, the President should insist on a strategy that restores support to law enforcement's counter-narcotics mission through a combination of block grants, increasing Byrne Grants, heightened drug prosecutions in the federal courts, and increased cross-over of high technologies available to the military but not yet economical to law enforcement.

These advances could be further aided by encouraging wider use of joint interagency task forces, which have tended to reduce jurisdictional conflicts, bureaucratic impediments, and restrictive regulations. The joint interagency task force concept has worked well, as examples like Operation Streetsweeper, a New Hampshire effort, illustrate. n220

Other potential policy changes appear on the demand reduction side. An effective National Drug Control Strategy must reaffirm the central place of drug prevention in the overall national drug strategy; respond to accountability concerns raised by the GAO and Department of Education investigations of prevention programs; and encourage greater private sector and media support for drug prevention efforts nationwide.

From a broader policy perspective, the Strategy must offer greater flexibility to states and localities, through mechanisms such as separate prevention block grants (which may become more accountable if authorized separately from treatment grants). Programs supported must be clearly limited to "no use" messages and "no use" curricula. More effort should be given to innovative means for encouraging cooperation between prevention and law enforcement, while increasing support for overlapping programs.

To protect effective drug prevention programs, Congress should only fund "validated" prevention programs, and -- on treatment -- should encourage establishment of generally accepted criteria for effective drug treatment. Where treatment works, it should be reinforced; Congress and the President should encourage greater application of effective treatment programs in correctional institutions. An effective Strategy should also explore means for establishing more overall treatment "slots," so long as the underlying [*408] treatment programs are effective. The Strategy must be intent on reducing the Washington "treatment bureaucracy," in order to allow a greater flow of funds to the states and localities.

On all demand reduction efforts, especially youth-targeted prevention, ONDCP and the Strategy should create opportunities for the President to speak out on the issue; in the end, his "bully pulpit" is the single most powerful prevention tool.

6. A Few Bold Ideas

Beyond the federal strategy, accountability, coordination, and the concrete changes proposed above, there are a few bold ideas that merit further consideration. Among these ideas, without passing judgement on their workability, legality, cost, or political viability in this Article, are the following.

A more comprehensive regime of private and public sector drug testing should be explored. Excellent legislation has recently been suggested by such groups as the Institute for a Drug-Free Workplace, including both incentives for voluntary corporate drug testing and in particular, new measures for safetysensitive positions. Privacy and civil rights

considerations must enter into the legislative calculus, but acceptability, societal needs, and the science surrounding drug testing are all evolving. Evolution in this area suggests opportunity. The time may soon be right for broad drug testing legislation.

Notably, recent tests indicate that drug testing through non-intrusive hair samples can be highly effective, and could be widely implemented. n221 A recent GAO report advised that HHS "give high priority to validating self-reports of use of illicit drugs, particularly by focusing on objective techniques such as hair testing," n222 and set forth six detailed reasons for endorsing new hair-testing technology. n223

[*409] Whether these developments counsel drug testing for the entire private sector, everyone tangentially benefiting from federal assistance, all federal employees, or merely a selected increase in testing remains an open question, but the need to re-visit this topic is fast approaching. Novel ideas worth added thought are drug testing in association with issuance of drivers' licenses and reduced liability for employers who voluntarily drug test.

Similarly, on the legal front, serious consideration should be given to expanding the reach of U.S. counternarcotics laws' through a review of current extraterritoriality limits; an effort to expand the legitimate reach of these laws could be pressed either through U.S. courts or through bilateral agreements with nations also struggling with the narcotics problem. A Panama-based counternarcotics center might coordinate regional efforts like Operation Green Clover and a regional riverine strategy.

As a general matter, the priority level associated with narcotics crime prosecution should be raised within the Department of Justice, and more thought should be given to specialized federal narcotics courts. The legal question should be explored whether U.S.-based pro-legalization groups might also be required to register as foreign agents if they receive any substantial funding from foreign drug-producing or processing nations. Federal agencies should be restricted from cooperation with any pro-legalization groups, with the exception of legalization of otherwise illicit drugs for specific, FDA-approved or regulated medical purposes, such as morphine for pain. Federal encouragement for corporate anti-drug efforts should be expanded.

Other ideas worth revisiting are broader application, perhaps in Colombia, Bolivia, and Mexico, of the successful Peruvian "shoot down" policy, through which Peru has dissuaded many narco-traffickers. n224

There are many untried and plainly bold ideas, some of which are worth rethinking. These are a few. The time is fast-approaching, however, when greater willingness to confront drug abuse [*410] and narco-trafficking through novel approaches will be necessary.

7. One Closing Thought

Overall, this blueprint is only a starting point for the next President, the next Congress, and the next White House Drug Czar. A great deal more thought and detail will be required over the next decade (or longer) to actually turn back the rising tide of drug abuse and trafficking. Clearly, a crisis is upon us, and it is for our children that we must now sit up and take notice. As a matter of national policy, we must recognize both the gravity of the present crisis and the room that exists for optimism. We must together engage in re-designing our national strategy, and simultaneously improving implementation of that strategy. Like it or not, our nation's drug control policy is collapsing. We must now rebuild it, based on a sound blueprint, before our own indifference remakes the society in which we live. At the personal level, as well as at the national level, that responsibility belongs to all of us.

Legal Topics:

For related research and practice materials, see the following legal topics:
EvidenceScientific EvidenceToxicologyGovernmentsFederal GovernmentDomestic SecurityGovernmentsPublic ImprovementsCommunity Redevelopment

FOOTNOTES:

n1 "National Drug Control Policy" is a term of art that first appeared in the national lexicon in the wake of the Anti-Drug Abuse Act of 1988. Pub. L. No. 100-690, 102 Stat. 4189 (codified as amended at 21 U.S.C. §§ 1501-1508 (1994)). This Act created the Office of National Drug Control Policy ("ONDCP") and provided it with a director, popularly known as the "White House Drug Czar." *Id.*

n2 Consistent with the Anti-Drug Abuse Act of 1988 and contributing to the increased currency of the term "National Drug Control Policy" was the statutory requirement that the Drug Czar annually present to Congress and to the President a federal Drug Control Budget and a "National Drug Control Strategy." *Id.* Between 1988 and 1996, with the exception of 1993, there has been compliance with the statute. In 1993, President Clinton argued that he did not have time to comply. It was not until more than six months after his election that he nominated an ONDCP Director, Dr. Lee P. Brown, and finally presented a full National Drug Control Strategy in February 1994.

n3 DAVID F. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL 256 (1987).

n4 In 1979, 54% of youth respondents to the Monitoring the Future Survey indicated drug use. *See* PRIDE, 1995 REPORT 1 (1995).

n5 In hearings in early 1995, the Chairman of the Subcommittee on National Security, International Affairs and Criminal Justice, Representative William H. Zeliff, Jr. (R-N.H.), noted that Reagan "woke the nation up to this [juvenile drug abuse] problem and its pervasiveness in the early 1980's." Zeliff also observed that the former First Lady's "Just Say No" campaign effectively launched a "national crusade" for drug abuse prevention. He reminded America that, in April 1985, Reagan held the first International Drug Conference for the world's First Ladies; in 1988, she held the second such conference and became the first American First Lady to speak before the United Nations; and after leaving the White House, she founded the Nancy Reagan Foundation, which has since "awarded grants in excess of $ 5 million to drug prevention and education programs . . . ." *Effectiveness of the National Drug Control Strategy and the Status of the Drug War: Hearings Before the National Security, International Affairs and Criminal Justice Subcomm. of the Comm. on Gov't Reform and Oversight*, 104th Cong., 1st Sess. 11-12 (1995) [hereinafter *Effectiveness Hearings*] (statement of Rep. Zeliff).

n6 The term "Drug War" is employed throughout this Article to denote the entire gamut of federal counter-narcotics efforts, including transit-zone interdiction, international source country programs, domestic prevention and treatment programs, law enforcement, and other federal support efforts. The specific budget request and appropriation numbers for these programs, and the cuts that have been permitted in them, are discussed in detail below.

n7 *See* 21 U.S.C. § 1504 (1988).

n8 Pub. L. No. 103-322, 108 Stat. 1796 (1994).

n9 In fact, this two percent measure has proved more theoretical than actual, as particular agency heads have resisted the transfers and prevailed in those efforts.

n10 H.R. 1868, 104th Cong., 1st Sess. (1995).

n11 S. 1548, 104th Cong., 1st Sess. (1995).

n12 H.R. 2248, 104th Cong., 1st Sess. (1995).

n13 For descriptions of other recent legislation affecting the Nation's Drug Control Policy, see OFFICE OF NATIONAL DRUG CONTROL POLICY, THE WHITE HOUSE, THE NATIONAL DRUG POLICY 56 (1995) (describing the Safe and Drug Free Schools and Communities Act of 1994 ("SDFSCA"), the National Commission on Drug-Free Schools, drug treatment programs, and the Drug Court Initiative) [hereinafter THE NATIONAL DRUG POLICY, 1995].

Demand-reduction programs are also administered by various federal agencies, including the Departments of Health and Human Services ("HHS"), Education ("DoEd"), and Defense ("DoD"). Other legislation obviously affecting demand-side programs are the appropriation measures required to support authorized demand-reduction. *Id.*

On the supply-reduction side, recent legislation affecting the Nation's Drug Control Policy includes, the International Narcotics Control Corrections Act of 1994, which exempted Fiscal Year ("FY") 1995 narcotics-related military assistance from general prohibitions on aiding law enforcement, waived restrictions on narcotics-related economic assistance, and gave the President authority to aide international counternarcotics efforts on such terms as he may determine fit. *See* International Narcotics Control Corrections Act of 1994, Pub. L. No. 103-447, 108 Stat. 4691-98 (codified as amended in scattered sections of 7, 8, 12, 18, 19, 21, 22 U.S.C.). In addition, a variety of appropriation bills supported or affected the supply-reduction programs, including the Foreign Operations Appropriations for FY 1995, approving $ 105 million for the State Department's international narcotics programs, and creating a major new weapon in National Drug Control Policy by authorizing the President to deny foreign military financing to Colombia and Bolivia unless he certifies that it will be used primarily for narcotics-related activities (following the model of other historic de-certification legislation), and further barring debt relief by the United States for any nation that does not cooperate in international narcotics control efforts. *See* Foreign Operating Appropriations for FY 1995, Pub. L. No. 103-306, 108 Stat. 1608-58 (codified as amended in scattered sections of 2, 7, 10, 22, 36, 50 U.S.C.).

Somewhat perilously, the Department of Defense Appropriations Act of 1995 and the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1994, respectively, reduced drug interdiction and counterdrug funding at DoD by approximately $ 150 million, from $ 868.2 million in FY 1994 to $ 721.266 million in FY 1995, and reduced funding to the State Department's international narcotics control programs by nearly $ 50 million, from $ 147.8 million in FY 1993 to $ 100 million in FY 1994. *See* Department of Defense Appropriations Act of 1995, Pub. L. No. 103-335, 108 Stat. 2599-2660 (codified as amended in scattered sections of 10, 22, 41, 50 U.S.C.); Foreign Operations, Export, Financing, and Related Programs Appropriations Act of 1994, Pub. L. No. 103-87, 107 Stat. 931-76 (codified as amended in scattered sections of 2, 5, 12, 22, 50 U.S.C.).

Finally, additional significant legislation, which affected both demand- and supply-reduction, includes the Emergency Supplemental Appropriations and Rescissions Bill for FY 1995 that cut previously unspent funding for portions of selected drug-related programs in the 1994 Crime Control Act, including the so-called drug courts ($ 17.1 million), the Family and Community Endeavor Schools grants at DoEd ($ 11.1 million), and the Community Schools Youth Services at HHS ($ 15.9 million). It also transferred $ 13.2 million from the ONDCP Special Forfeiture Fund to the U.S. Customs Service for implementation of a new border enforcement initiative called Operation Hardline. *See* Emergency Supplemental Appropriations for Additional Disaster Assistance, for Anti-Terrorism Initiatives, for Assistance in the Recovery from the Tragedy that Occurred at Oklahoma City, and Rescissions Act of 1995, Pub. L. No. 104-19, 109 Stat. 194-254 (codified as amended in scattered sections of 5, 20, 23, 26, 40, 42 U.S.C.). The Federal Sentencing Guidelines, Amendment, Disapproval was also key 1995 legislation. It disapproved the amendments proposed by the U.S. Sentencing Commission that would have reduced mandatory minimum sentences for crack cocaine and money laundering transactions, and simultaneously raised the penalties for distributors of powder cocaine by widening the dealer population to which current mandatory minimums apply; this provision was strongly advocated by Representative Zeliff and Representative William McCollum (R-Fla.). In the absence of this legislation, the Sentencing Commission amendments would have gone into effect on November 1, 1995. *See* The Federal Sentencing Guidelines, Amendment, Disapproval, Pub. L. No. 104-38, 109 Stat. 334-35 (1995) (codified as amended in 28 U.S.C. § 994).

n14 *See* H.R. 1488, 104th Cong., 2d Sess. (1995); H.R. 2076, 104th Cong., 2d Sess. (1995); H.R. 728, 104th Cong., 2d Sess. (1995).

n15 *See* S. 3, 104th Cong., 2d Sess. (1995); S. 1398, 104th Cong., 2d Sess. (1995).

n16 *See, e.g., The National Drug Control Strategy: Hearing Before the Legis. and National Security Subcomm. and Joint Hearings Before the Legis. and National Security Subcomm. and Gov't Information, Justice*

and Agric. Subcomm. of the Committee on Gov't Operations, 101st Cong., 1st Sess., vol. 1 (1989) [hereinafter *1989 Hearings on The National Drug Control Strategy, vol. 1*]; *The National Drug Control Strategy: Hearing Before the Legis. and National Security Subcomm. and Joint Hearings Before the Legis. and National Security Subcomm. and Gov't Information, Justice and Agric. Subcomm. of the Committee on Gov't Operations*, 101st Cong., 1st, 2d Sess., vol. 2 (1990) [hereinafter *1990 Hearings on The National Drug Control Strategy, vol. 2]; The National Drug Control Strategy: Hearing Before the Legis. and National Security Subcomm. and Joint Hearings Before the Legis. and National Security Subcomm. and Gov't Information, Justice and Agric. Subcomm. of the Committee on Gov't Operations*, 101st Cong., 2d Sess., vol. 3 (1990) [hereinafter *1990 Hearings on The National Drug Control Strategy, vol. 3*]. Volume One of these oversight hearings allowed for Administration presentations and a brief discussion of interdiction and the Andean Initiative, while Volume Two focused on "The Impact on the State of Michigan," "The Impact on the State of California," and "The Impact on the State of Illinois." Volume Three addressed prevention, treatment and law enforcement programs, but seemed to favor treatment-oriented demand-reduction and promoted the view that demand-reduction and supply-reduction efforts must be viewed in competition, rather than recognizing that interdiction and source country programs, if effective, reduce street availability and purity, raise price, and make prevention more likely to succeed. On the other hand, effective prevention reduces overall casual use, shrinks the number of users likely to become addicted, and reduces the burden on the criminal justice system, law enforcement, and treatment programs. Finally, reducing the demand for illegal drugs and reducing the growth of demand reduces the incentive for increased production, thus aiding supply-side efforts, including coca crop eradication and alternative crop production in the source countries. Interestingly, the expert testimony at these hearings does not support the view that interdiction and prevention should take a back seat to drug treatment; in fact, some advocates of greater federal attention to drug treatment conceded that effectiveness measures are lagging in the area of drug treatment. For example, Karst J. Besteman testified that, among the faults of the 1990 Strategy, was "the emphasis of [sic] expansion of treatment capacity by the federal government with little or no assistance to improve its quality and effectiveness." While Besteman offers one argument for more federal funding to aid research into the efficacy of drug treatment, his testimony is also a persuasive argument against open-ended funding of drug treatment programs not proven to be effective. *1990 Hearings on "The National Drug Control Policy," vol. 3, id.* at 188 (testimony of Karst J. Besteman, Executive Director of the Alcohol and Drug Abuse Problems Association).

n17 *1990 Hearings on The National Drug Control Strategy, vol. 3, supra* note 16, at 151 (statement of Rep. Conyers). In addition, contrary to expert testimony indicating the absence of effective drug treatment programs and confirming that few if any publicly funded drug treatment programs offered encouraging rates of success with crack or cocaine addicts, Conyers nevertheless maintained that "preliminary research indicates that drug treatment reduces drug abuse, increases employment and decreases crime." *Id.* at 152. Indeed, these hearings appear to have been intended to buttress unrelated priorities. For example, expressing "serious reservations about the general orientation" of the 1990 Strategy, which funded interdiction, source country programs, and prevention programs ahead of drug treatment programs, Chairman Conyers took the discussion far afield of counter-narcotics policy, asking then-Drug Czar William Bennett, "Isn't it impossible to fight a war on drugs without fighting a war on poverty, homelessness, unemployment, teenage pregnancy, and the overall despair about the future?" *1989 Hearings on "The National Drug Control Strategy," vol. 1, supra* note 16, at 19.

n18 *Drugs in the 1990s: Emerging Trends; The Challenges Facing the Drug Enforcement Administrations, the Justice Department, and the Coast Guard: Hearing Before the Information, Justice, Transp., and Agric. Subcomm. of the Committee on Gov't Operations*, 103d Cong., 2d Sess. (1994) [hereinafter *1994 Hearings on Drugs in the 1990s*]. *See also infra* notes 19 and 21 and accompanying text.

n19 The damaging effects of drugs on the body have been widely reported. The most authoritative data is collected from emergency rooms around the country and presented by HHS in the annual Preliminary Estimates From The Drug Abuse and Warning Network, or "DAWN," data. DAWN data released in September 1995 demonstrates the harms associated with drugs, as well as the recent increases in juvenile drug use.

Specifically, the 1995 DAWN data shows that "cocaine-related episodes reached their highest level in history," heroin-related episodes have been increasing since the early 1980s, "marijuana/hashish-related episodes

rose from 28,900 in 1993 to 40,100 in 1994, a 39 percent increase," and "the 1994 estimates of total drug-related hospital emergency department episodes continued an upward trend begun in 1991." SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., DEP'T OF HEALTH AND HUM. SERVICES, 1994 PRELIMINARY ESTIMATES OF DRUG-RELATED EMERGENCY DEPARTMENT EPISODES 11 (1995) [hereinafter 1994 PRELIMINARY ESTIMATES].

The 1995 emergency room data also indicates that "drug related episodes rose by 58 percent (from 323,100 to 508,900) from 1978 to 1994, while emergency department visits increased by 21 percent (from 71.3 million to 86.1 million)," *id.* at 6, and "the rate of drug-related episodes per 100,000 population increased 32 percent" from 1990 to 1994. *Id.* at 6.

Of the remaining 1995 DAWN facts, four stand out: "Between 1993 and 1994, the number of drug-related episodes rose by 17 percent for persons aged 12 to 17 years," *id.* at 6; "dependence" and "recreational use" were both listed as "motives" for drug use producing these emergencies, *id.* at 7; "the most frequently recorded reason for a drug-related emergency department visit was 'overdose' . . . which composed 51 percent of all episodes and increased by 16 percent since 1991;" *id.* at 7, and the "proportion of drug-related episodes that are heroin-related has increased steadily from 4 percent in 1978 . . . to 13 percent in 1994 . . . ." *Id.* at 8. Accordingly, it can hardly be said that there are not significant and damaging health effects associated with each drug named in the 1995 DAWN data, including heroin, cocaine, and marijuana/hashish.

Independently, Dr. Mark Gold, professor of neuroanatomy at the University of Florida, is reported to have recently found that "all drugs change the brain chemistry," and "marijuana and cocaine alter both human genes and neuroreceptors." WILLIAM R. CALTRIDER, JR., CTR. FOR ALCOHOL AND DRUG RESEARCH AND EDUC., THE FOLLY OF MARIJUANA LEGALIZATION 5 (1995).

Likewise, Caltrider reports that "the respiratory burden" and "physiological insult" created by "one joint of marijuana" is "400% greater than [by] a commercial tobacco cigarette," that "use of marijuana as infrequently as once a month will insure consistent retention of a baseline level of THC and byproducts in lipid tissues, the brain, lungs, liver and reproductive organs of the user," and meaning that "there is no safe daily dose of marijuana, a drug whose psychoactive agent is fat-soluble and tenaciously persistent within the human body." *Id.* at 5-6.

Importantly, the definition of marijuana has also been changing, and this bears on health effects. "The THC content of current street-grade marijuana is 2500% more potent than that of the late 1960's . . . ." *Id.* at 6.

n20 *See 1994 Hearings on Drugs in the 1990's, supra* note 18, at 35-37.

n21 There have been sporadic efforts to legalize narcotics, often under the rubric of "legalization," "decriminalization," "medicalization," or "harm reduction," by groups such as NORML, for years. Most recently, at a Harvard Law School Conference on May 21, 1994, nine legalization or harm reduction advocates were invited to share their views. Whether the intent of the conference was to openly air, promote, or discredit the pro-legalization advocates, their expressed views speak for themselves. These views were included in a recent paper by William R. Caltrider, Jr., president of the Center for Alcohol and Drug Research and Education, a nonprofit public policy information clearing house. According to Caltrider's report, Richard Cowan, the national director of NORML, indicated at the Harvard conference that drug prohibition "policies are no more effective than those of Stalin and Hitler," "millions of people are harmed by your [drug] policies, not the drug itself." Similarly, Caltrider reports that another legalization advocate presented the case that society suffers from "addictiphobia" and professed that "marijuana is a harmless drug." John Morgan of City University of New York apparently explained that "cocaine does not cause physical dependence," adding that "when we know drugs are dangerous, we should legalize them," since "prohibiting dangerous drugs is foolish." Representative Barney Frank (D-Mass.) is reported to have said that "drug laws are among the most stupid parts of our culture," and "people like Kurt Schmoke [mayor of Baltimore, who urges drug legalization] are enormously courageous." Finally, the reported comments of Orange County Circuit Court Judge James Gray, as recorded by Caltrider, include the view that "the very worst thing would be the [sic] close our borders and keep drugs out," and the dismaying assertion by a member of the judiciary that "we made a 17 percent gain (in a public poll) in favor of legalization in one year in Orange County." William R. Caltrider, Rhetorical Disinformation in Drug Policy Debate, Address at PRIDE International Conference (Mar. 24, 1995) (on file with the author).

n22 *See supra* note 19 and accompanying text. In addition, however, note that the National Institute on Drug Abuse (NIDA) at the National Institutes of Health reported in 1995 that "research has shown marijuana use has many serious and harmful effects." Elaborating, NIDA reported that:

> Short-term or acute effects of marijuana include impairments in learning and memory, perception, judgement, and complex motor skills . . . . Marijuana can cause difficulty speaking, listening effectively, thinking, retaining knowledge, problem solving and forming concepts. An "amotivational syndrome" can develop in heavy, chronic marijuana users. It is characterized by decreased drive and ambition, shortened attention span, poor judgement, high distractibility, impaired communications skills, and diminished effectiveness in interpersonal situations . . . . Judgement of speed and time are impaired by marijuana use, making driving particularly hazardous. In one study of more than 1,000 accident victims at a shock trauma unit, 35% were found to have detectable levels of marijuana in their blood . . . . Regular use of marijuana -- with or without other illicit drugs -- is correlated with higher levels of truancy, fighting, delinquency, arrests, and health problems in adolescents . . . . Physiological effects of marijuana include an alteration of heart rate. Use of marijuana may result in intense anxiety, panic attacks or paranoia . . . . Marijuana smoke contains some of the same carcinogens and toxic particulates as tobacco, sometimes in higher concentrations. Daily use of 1 to 3 joints appears to produce the same lung diseases (bronchitis, emphysema, and bronchial asthma) and potential cancer risk as smoking five times as many cigarettes.

NATIONAL INSTITUTE ON DRUG ABUSE AND NATIONAL INSTITUTES OF HEALTH, THE FACTS ABOUT MARIJUANA 1 (1995).

n23 *See supra* note 16 and *infra* note 24.

n24 *See, e.g.*, OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION, U.S. DEP'T OF JUSTICE, JUVENILE OFFENDERS AND VICTIMS: A NATIONAL REPORT (1995) [hereinafter 1995 OJJDP REPORT]. Among other findings, the 1995 OJJDP report found that "1 in 3 juvenile detainees were [sic] under the influence of drugs at the time of their offense," and according to the National Institutes of Justice Drug Use Forecasting ("DUF") data, "overall, the 12 [DUF detention center] sites in 1993 reported that between 18% and 54% of juveniles tested positive for at least one illicit drug" at the time of arrest, and "the average proportion of positive [juvenile] tests was 33% . . . substantially above the 1992 average of 25%." *Id.* at 64-65. In addition, "the crime most commonly committed [by juveniles] under the influence of drugs was burglary," and "crimes committed most often to obtain drugs were drug selling (36%), serious assault (24%), burglary (24%), and robbery (19%)." *Id.* at 64. Finally, so there can be no minimization of the correlation between rising juvenile crime and rising juvenile use of marijuana, the 1995 OJJDP report notes that "the level of marijuana use in 1993 [i.e., positive test at arrest] ranged from 14% to 51% [among the 12 test sites] of the juveniles tested, with an average value of 26% . . . substantially above the 1992 average of 16.5%." *Id.* at 65.

On rising violent juvenile crime, the Justice Department found that, "after years of relative stability, juvenile involvement in violent crime known to law enforcement has been increasing." *Id.* at 1. Moreover, DoJ indicates that "if juvenile arrest rates for Violent Crime Index offenses (murder, rape, robbery, and aggravated assault) were to remain fixed at the 1992 level, juvenile population growth alone would produce a 22 percent rise in violent juvenile crime arrests." More forebodingly, DoJ concludes, "Should the juvenile crime arrest rates increase in the future . . . juveniles arrested for these violent crimes would double by the year 2010 . . . ." *Id.*

Finally, Caltrider observes that, "drug use and criminal activity are inextricably linked" and "between 50-80% of felony arrestees nationwide test positive for some single or multiple illicit drug(s) at the time of the arrest for a non-drug crime." CALTRIDER, THE FOLLY OF MARIJUANA LEGALIZATION, *supra* note 19, at 7.

n25 The Columbia University Center on Addiction and Substance Abuse, led by former President Jimmy Carter's Secretary of Health Education and Welfare ("HEW"), Joseph Califano, and former Demand Reduction Deputy ONDCP Director under President Bush, Herbert Kleber, in a joint press release with former Drug Czar William Bennett, recently warned that, "If historical trends continue, the jump in marijuana use among America's children (ages 12-18) from 1992 to 1994 signals that 820,000 more of these children will try cocaine in their lifetime. Of that number, about 58,000 will become regular cocaine addicts and users." Untitled Press Release from Joseph Califano and William Bennett (Sept. 1995) [hereinafter Califano and Bennett Press Release].

n26 *See infra* notes 51 and 54 and accompanying text.

n27 *See supra* notes 19, 22 and 24 and *infra* notes 51 and 54.

n28 *See, e.g.*, GENERAL ACCOUNTING OFFICE, COMMUNITY BASED DRUG PREVENTION: COMPREHENSIVE EVALUATIONS OF EFFORTS ARE NEEDED (1993); GENERAL ACCOUNTING OFFICE, WAR ON DRUGS: FEDERAL ASSISTANCE TO STATE AND LOCAL DRUG ENFORCEMENT (1993); GENERAL ACCOUNTING OFFICE, DRUG CONTROL: REVISED DRUG INTERDICTION APPROACH IS NEEDED IN MEXICO (1993); GENERAL ACCOUNTING OFFICE, DRUG CONTROL: REAUTHORIZATION OF THE OFFICE OF NATIONAL DRUG CONTROL POLICY (1993) [hereinafter REAUTHORIZATION]; GENERAL ACCOUNTING OFFICE, INS DRUG TASK FORCE ACTIVITIES: FEDERAL AGENCIES SUPPORTIVE OF INS EFFORTS (1994).

n29 *See Effectiveness Hearings, supra* note 5.

n30 During the 1995 investigation into the status of the National Drug Control Strategy and its implementation, the Subcommittee engaged in extensive correspondence with the Administration, including direct correspondence with the President; the Vice President; the President's National Security Advisor, Anthony Lake; the Director of ONDCP, Dr. Lee P. Brown; the United States Interdiction Coordinator and Coast Guard Commandant, Admiral Robert E. Kramek; the Administrator of the Drug Enforcement Administration, Thomas A. Constantine; the Commissioner of the U.S. Customs Service, George Weise; the Department of Defense Deputy Assistant for Drug Enforcement Policy, Brian Sheridan; the Department of State Deputy Assistant Secretary for International Narcotics and Law Enforcement, Ambassador Jane E. Becker; and others at the Departments of Justice, Defense, State, ONDCP, and elsewhere in the Administration.

The Subcommittee investigation also included a June 1995 fact-finding trip to the Seventh Coast Guard District in the Caribbean transit zone, which involved high-level briefings at Seventh District Headquarters in Miami on Coast Guard interdiction initiatives at sea, Drug Enforcement Administration (DEA) activities in the Greater Antilles, and interagency working group activities in Puerto Rico involving the FBI, DEA, Customs, Border Patrol, and local authorities. The Subcommittee also received in-depth briefings by Admiral Granuzo and others at the Joint Interagency Task Force-East in Key West, Florida, dedicated to Eastern Caribbean Drug Interdiction. In coordination with ONDCP, Subcommittee Chairman Zeliff also traveled with the White House Director of ONDCP for prevention and treatment programs in New England.

In general, the Subcommittee met extensively with the Federal agencies involved in implementing the National Drug ControlStrategy and relied upon statistical and anecdotal evidence pertaining to the effectiveness and accountability of the current National Drug Control Strategy and programs. Efforts under inquiry spanned interdiction, law enforcement, prevention, treatment, and source country initiatives. The Subcommittee was assisted by GAO investigators, field agents, and departmental inspectors general.

n31 1995 OJJDP REPORT, *supra* note 24, at 58-65.

n32 In November 1993, the President promised a national heroin strategy within 120 days. As testimony indicated throughout hearings in 1995, no heroin strategy was ever produced. Without White House announcement, the President finally signed a national heroin strategy in late November 1995. Because the signed strategy

offers little that is new, is weak on details, and was promulgated without implementing guidelines, it has been a nullity so far. However, there is hope that with the nomination of a new ONDCP director, namely General Barry McCaffrey, the implementing guidelines will appear, and the heroin strategy will be integrated into a more coherent overall strategy.

n33 *See infra* notes 84-122 and accompanying text.

n34 *See infra* notes 125-134 and accompanying text.

n35 In particular, reports of waste and misapplication of funds have been associated with certain states' administration of Safe and Drug Free Schools monies. These allegations are presently under investigation by the Department of Education and GAO.

n36 *See Effectiveness Hearings, supra* note 5, at 114 (statement of Thomas Hedrick, Vice Chairman of the Partnership for a Drug-Free America). Hedrick continues, "[since the Partnership's inception,] the nation's media has donated over $ 2 billion in time and space to get our anti-drug messages to the public. In 1990 and 1991, this translated to 1 anti-drug message per household per day. However, support of our messages has declined by 20 percent over the past three years because the media is not as convinced that the drug issue is as important as it was." *Id.*

Hedrick also noted, "There has been an even more dramatic decrease in the news coverage of the drug issue . . . going from about 600 stories in the 3 major networks in 1989 to 65 which, quite frankly, from a communications point, ladies and gentlemen, is about zero." *Id.* at 112.

n37 *See supra* note 24 and accompanying text.

n38 *See Effectiveness Hearings, supra* note 5, at 100-04 (statement of Admiral Paul A. Yost, USCG (retired), president, James Madison Memorial Fellowship Foundation).

n39 NATIONAL INSTITUTE OF DRUG ABUSE, DEP'T. OF HEALTH AND HUM. SERVICES, MONITORING THE FUTURE STUDY, 1975-1994: NATIONAL HIGH SCHOOL SENIOR DRUG ABUSE SURVEY (1994) [hereinafter MONITORING THE FUTURE STUDY].

n40 *Id.* at 4.

n41 The *Monitoring the Future Study* is highly regarded within the drug-prevention community. Data are collected annually in the spring from public and private junior and senior high schools throughout the country, excepting Alaska and Hawaii. The survey covers both trends in use and prevalence of drug use and addresses 20 classes and subclasses of drugs, including marijuana/hashish (up 2.7% in 1993 and up 2.9% in 1994, after falling 4.1% in 1992), inhalants (up 0.8% in 1993 and up 0.3% in 1994, after falling 1.0% in 1992), LSD (up 1.7% in 1993 and up 0.2% in 1994, after falling 0.2% in 1992), PCP (up 0.5% in 1993 and down 0.1% in 1994, after falling 0.5% in 1992), cocaine (level in 1993, after falling 1.7% in 1992, falling 1.6% in 1991, falling 0.9% in 1990, falling 1.8% in 1989, falling 3.1% in 1988, falling 1.7% in 1987, and falling 0.4% in 1986), crack (level in 1993 and up 0.4% in 1994, after falling 0.5% in 1992, falling 0.4% in 1991, falling 1.2% in 1990, falling 0.1% in 1989 and falling 0.6% in 1988, before which crack was not measured), heroin (level in 1993 and 1994, after a 0.3% increase in 1992), stimulants (up 1.2% in 1993 and 0.6% in 1994, after falling steadily from a high of 32.2% in 1981 to a low of 13.9%), crystal methamphetamine (up 0.2% in 1993 and 0.3% in 1994, after falling 0.5% in 1992), sedatives (up 0.3% in 1993 and up 0.9% in 1994, after falling 0.6% in 1992), barbiturates (up 0.8% in 1993 and up 0.7% in 1994, after falling 0.7% in 1992), and tranquilizers (up 0.4% in 1993 and up 0.2% in 1994, after falling 1.2% in 1992). Also included in the study were anabolic steroids, non-LSD hallucinogens, other opiates, methaqualone, amyl and butyl nitrites, and alcohol. Questions include inquiries into age of first

use, trends in use at earlier grade levels, intensity of drug use, attitudes and beliefs concerning various types of drug use, and perceptions of peer attitudes. MONITORING THE FUTURE STUDY, *supra* note 39, at 2.

n42 *Id.* at 4.

n43 SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., DEP'T. OF HEALTH AND HUM. SERVICES, 1993 PRELIMINARY ESTIMATES OF DRUG-RELATED EMERGENCY DEPARTMENT EPISODES 2-8 (1994).

n44 SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., DEP'T. OF HEALTH AND HUM. SERVICES, PRELIMINARY ESTIMATES FROM THE 1994 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE (1995).

n45 PRIDE, TEEN DRUG USE RISES FOR FOURTH STRAIGHT YEAR, 1-4 (1995). *See also* THOMAS J. GLEATON, ET AL., PRIDE COMMUNITIES: A GRASSROOTS DRUG PREVENTION EFFORT FOR HEALTHY TEENS (1995).

n46 1994 PRELIMINARY ESTIMATES, *supra* note 19, at 11.

n47 *Effectiveness Hearings, supra* note 5, at 13-16 (statement of Former First Lady Nancy Reagan); *id.* at 11-13 (remarks of Rep. Zeliff).

n48 *Id.*

n49 *See Effectiveness Hearings, supra* note 5, at 103-04 (statement of Paul A. Yost).

n50 *Effectiveness Hearings, supra* note 5, at 14 (testimony of Nancy Reagan). *See also id.* at 18 (statement of John P. Walters, President, New Citizenship Project); at 47 (statement of William J. Bennett, Former Drug Czar); at 42-43 (statement of Judge Robert C. Bonner, Former Director, Drug Enforcement Agency). In the foregoing hearings, Walters testified that "overall, casual drug use by Americans dropped by more than half [between 1977 and 1992] . . . [and] between 1985 and 1992 alone, monthly cocaine use declined by 78 percent," noting that "[a] 50-80 percent reduction in a similar social problem (the dropout rate, illegitimacy, the spread of HIV, or the rate of violent crime) would be considered a major domestic policy success -- that is what happened with illegal drug use in the U.S." *Id.* at 18. Bonner added that, "crack cocaine use sharply declined from nearly half a million in 1990 to just over 300,000 two years later in 1992," and observed that, "in virtually every category of illegal drug, we saw sharp declines from the mid-1980s through 1992," including "an astonishing 61 percent decline" of regular marijuana users between 1985 and 1992. *Id.* at 43.

n51 *See Effectiveness Hearings, supra* note 5, at 31-37 (testimony of John P. Walters).

n52 1995 OJJDP REPORT, *supra* note 24, at 64.

n53 *Id.* at 64-65.

n54 The 1995 OJJDP Report also notes that, "the crime most commonly committed [by juveniles] under the influence of drugs was burglary," and "crimes committed most often to obtain drugs were drug selling (36%), serious assault (24%), burglary (24%), and robbery (19%)." *Id.* at 64-65.

The OJJDP Report also indicates that "if juvenile arrest rates for Violent Crime Index offenses (murder, rape, robbery, and aggravated assault) were to remain fixed at the 1992 level, juvenile population growth alone would produce a 22 percent rise in violent juvenile crime arrests by the year 2000." More forebodingly, DoJ warns: "Should the juvenile crime arrest rates increase [at current rates] in the future . . . juveniles arrested for these violent crimes would double by the year 2010 . . . ." *Id.*

n55 *See* CALTRIDER, *supra* note 19, at 7 (observing that "drug use and criminal activity are inextricably linked . . . ." and "between 50-80% of felony arrestees nationwide test positive for some single or multiple illicit drug(s) at the time of the arrest for a non-drug crime.")

n56 *See supra* note 36 and accompanying text.

n57 *See* William H. Zeliff, Jr., *Missing Leader in the Drug World*, WASH. POST, Dec. 15, 1995, at A25.

n58 *See supra* note 6.

n59 *See* OFFICE OF NATIONAL DRUG CONTROL POLICY, 1996 NATIONAL DRUG CONTROL STRATEGY (1996). In this strategy, proposed April 25, 1996, treatment program spending rises to a record $ 2.9 billion dollars, while interdiction spending remains almost $ 100 million dollars below 1992 levels, and source country spending is $ 123 million dollars below 1992 levels. *Id.*

n60 DAVID TEASLEY, CONGRESSIONAL RESEARCH SERVICE REPORT NO. 95-943, at 1 (1995).

n61 THE NATIONAL DRUG POLICY, 1995, *supra* note 13, at 113.

n62 *Id.* at 113. An April 1996 report suggests an even steeper decline in drug interdiction than reported by the White House. *See* GENERAL ACCOUNTING OFFICE, DRUG CONTROL: U.S. INTERDICTION EFFORTS IN THE CARIBBEAN DECLINE (1996).

n63 *Id.*

n64 *Id.* at 119.

n65 *Id.* at 113.

n66 *See supra* note 59.

n67 *The National Drug Policy, supra* note 13, at 9, 20.

n68 21 U.S.C. § 1504(a)(2)(B) (1988).

n69 THE NATIONAL DRUG POLICY, 1995, *supra* note 13, at 53.

n70 21 U.S.C. § 1504(a)(2)(B) (1988). The National Drug Control Strategies prior to 1993 conformed with these requirements. Thus, the 1992 Strategy laid out "10 detailed goals with specific numerical and proportional targets," such as to "reduce current overall drug use by 15%."

n71 The Department of Defense ("DoD") has been designated the lead agency for air and maritime detection and monitoring. 10 U.S.C. § 124 (1988). Until late 1995, the Joint Interagency Task Force-East ("JIATF-East") was coordinated by DoD; it appears that chief responsibilities at JIATF-East have now passed to the U.S. Coast Guard with the retirement of Admiral Granuzo. For further discussion, see, e.g., NATIONAL INTERAGENCY COUNTERDRUG INSTITUTE, THE COUNTERDRUG MANAGERS COURSE, RESOURCE GUIDE, §§ 1-1 to 2-26 (1994).

n72 The United States Coast Guard, which is anachronistically part of the Department of Transportation, is the only federal agency with jurisdiction on the high seas and in U.S. territorial waters. 14 U.S.C. § 1 (1988). While it conducts other missions, such as search and rescue, it has a primary responsibility for interdiction of illegal drugs en route to the U.S. *Id.*

n73 The Drug Enforcement Administration ("DEA"), created in 1973, 5 U.S.C. Reorg. Plan 2 § 4 (1973), is the lead federal agency for the enforcement of counternarcotics, or drug and controlled substances laws. DEA is primarily responsible for investigating drug traffickers, enforcing laws and regulations barring the manufacture, distribution, dispensation or importation of controlled substances, and managing the drug intelligence system. Although not often viewedas operating outside the country, DEA maintains 19 field divisions with 100 field offices, a research laboratory, and a DEA Air Wing that offers air support domestically and abroad. DEA operates in 45 countries. DEA operates the El Paso Intelligence Center ("EPIC").

n74 The Federal Bureau of Investigation ("FBI") is our Nation's principal agency for the conduct of federal investigations, and is part of the Department of Justice. 28 U.S.C. § 531 (1988). In 1982, following the Attorney General's determination that drug trafficking was the top criminal problem facing the nation, the FBI was designated by the lead agency in seeking violations of the 1970 Comprehensive Drug Abuse and Control Act, and became the designated supervisor of DEA. The FBI's counterdrug organization features the Mexican Drug Traffickers Unit ("DTU"), and investigates major Mexican drug trafficking organizations. It also maintains a DTU in Colombia and elsewhere in South America. On the heels of the FBI's successful engagement of the La Cosa Nostra and Sicilian Mafia, the European and Asian DTU are now focused on organized crime groups such as La Camorra and N'Drangheta, as well as Asian drug trafficking organizations.

n75 The U.S. Customs Service is the Nation's chief border enforcement agency, 19 U.S.C. § 2071 (1988), and, as such, is responsible for facilitating and regulating the movement of traffic across the borders. Customs is central to the drug war, since it is charged with detecting and seizing large quantities of illegal narcotics destined for the U.S. at the border. Customs operates air, land, and marine operations.

n76 The State Department's Bureau of International Narcotics Matters coordinates U.S. international supply reduction and demand reduction strategies. Programs the State Department oversees include crop eradication, income replacement, investigations, intelligence and interdiction support. The Department has four basic missions, including maintenance of an air wing, crop eradication and in-country enforcement, in-country development and demand reduction assistance, and support for regional counternarcotics efforts, such as those developed by the Organization of American States ("OAS"), the U.S. Fund for Drug Abuse Control, and the Pan American Health Organization.

n77 The U.S. Border Patrol is the enforcement arm of the Immigration and Naturalization Service, and is responsible for border drug interdiction. 8 U.S.C. § 1357(a) (1988). More broadly, the INS seeks and apprehends illegal aliens and drug traffickers inside the United States. 8 U.S.C. § 1103(a) (1988).

n78 Also pivotal in the drug war are the activities of the National Drug Intelligence Center ("NDIC"), which reports to the Attorney General. 21 U.S.C. § 873 (1988). NDIC is located in Johnstown, Pennsylvania (with a Washington, D.C. satellite office) and amasses and assesses drug trafficking patterns and other critical drug intelligence. Other agencies involved in counternarcotics activities, while perhaps seeming far afield, include the U.S. Marshals Service, Federal Bureau of Prisons, International Criminal Police Organization ("INTERPOL,"

which reports to the Attorney General), Bureau of Alcohol Tobacco and Firearms ("BATF," which exercises jurisdiction over firearms offenses, but reports that 50% of law enforcement work is now drug-related), the Internal Revenue Service ("IRS," which handles trafficker tax compliance issues), the U.S. Secret Service (which handles counterfeiting and currency violations), Federal Aviation Administration ("FAA," which assists in identifying airborne traffickers), and -- central to all foreign counternarcotics operations -- the intelligence community, including the Central Intelligence Agency ("CIA"), Defense Intelligence Agency ("DIA"), and National Security Agency ("NSA").

n79 *See Effectiveness Hearings, supra* note 5, at 100-09. *See generally Illicit Drug Availability: Are Interdiction Efforts Hampered by a Lack of Agency Resources?: Hearings Before the National Security, International Affairs, and Criminal Justice Subcomm. of the Comm. on Government Reform and Oversight*, 104th Cong., 1st Sess. (1995) [hereinafter *Drug Availability Hearings*].

n80 *Effectiveness Hearings, supra* note 5, at 100-04 (testimony of Paul A. Yost).

n81 *Id.*

n82 *Id.*

n83 TEASLEY, *supra* note 60, at 1.

n84 THE NATIONAL DRUG POLICY, 1995, *supra* note 13, at 113.

n85 *Id.*

n86 *Id.* One example of damaging inconsistency in source country program funding was the decision to freeze program monies to Peru, in response to President Fujimori's suspension of the Peruvian constitution. In a recent trip to Peru, the author learned that President Fujimori's effort reduced the number of terrorist deaths caused by the terrorist group The Shining Path dramatically, from approximately 30,000 to 500. President Fujimori has also introduced a highly effective "force-down/shoot-down" policy that has had three clear effects: (1) the price of flying coca from Peru to Colombia has increased eightfold; (2) the price of coca in Peru has fallen tenfold; and (3) between 20% and 40% of Peru's coca farmers have abandoned their fields; this is significant because two-thirds of the world's coca is grown in Peru. U.S. aid should have been released earlier; to be effective, source country programs must be coordinated and funded consistently. In addition, recent assessments of the overall spending on the "Andean Strategy" and other source country programs in Colombia, Bolivia, and Peru show that the "controlled shift" of resources to these countries never occurred. This reality was best described by Senator Hatch in a December 1995 study. This report noted that the Administration's cut in interdiction funding was supposed to have been balanced by enhanced concentration on institution-building and interdiction in the source countries of Latin America -- an idea recognized by some for its similarity to the Bush Administration's Andean Strategy. Yet more than 18 months after unveiling the new strategy, however, ONDCP Director Brown acknowledged to a congressional committee that the shift had not taken place:

> Foreign assistance funding to the Andean region has, in fact, been steadily declining . . . . International counternarcotics funding to the Andean region fell abruptly under the Clinton Administration, from $ 334.9 million in fiscal year 1993 to $ 131.8 million in fiscal year 1995 -- a 60 percent drop, and significantly less than the $ 470.3 million appropriated in fiscal 1992 under President Bush.

SENATOR ORRIN HATCH, LOSING GROUND AGAINST DRUGS: A REPORT ON INCREASING ILLICIT DRUG USE AND NATIONAL DRUG POLICY (1995) [hereinafter LOSING GROUND].

n87 *Effectiveness Hearings, supra* note 5, at 101 (testimony of Paul A. Yost).

n88 *Id.*

n89 *Id.* at 105.

n90 *Id.* at 101.

n91 NASSAU COUNTRY OFFICE, DRUG ENFORCEMENT ADMINISTRATION, OPERATION BAHAMAS AND TURKS AND CAICOS 7-8 (1995).

n92 Unclassified memorandum from United States Customs, Department of Treasury, to Director of DAICC (Dec. 18, 1995) (pertaining to R.O.T.H.R. User Enhancement Meeting) (on file with the author).

n93 This information stems from 1996 visits by the author to Puerto Rico, Mexico, Panama, Colombia, Bolivia, and Peru.

n94 THE WHITE HOUSE, OFFICE OF NATIONAL DRUG CONTROL POLICY, NATIONAL DRUG CONTROL BUDGET SUMMARY 41 (February 1995).

n95 *Id.*

n96 Unclassified Memorandum from the Office of the United States Interdiction Coordinator, Summary of USCG FY1994 Budget Reduction of $ 9M, Directed at Drug Interdiction Funding, (June 9, 1995) (on file with the author) [hereinafter USIC Memorandum].

n97 *Id.*

n98 *Id.*

n99 *Id.*

n100 *Effectiveness Hearings, supra* note 5, at 22-23 (statement of John P. Walters).

n101 *Id.* at 22.

n102 USIC Memorandum, *supra* note 96.

n103 *Effectiveness Hearings, supra* note 5, at 51 (testimony of John P. Walters).

n104 *Id.* at 22.

n105 *Effectiveness Hearings, supra* note 5, at 48 (statement of William J. Bennett).

n106 *Id.*

n107 *Effectiveness Hearings, supra* note 5, at 41 (statement of Robert C. Bonner).

n108 *Id.* at 43.

n109 *Id.* at 44.

n110 *Id.* at 51.

n111 *Id.* at 44.

n112 Unclassified Letter from Admiral Robert Kramek to Lee Brown, White House ONDCP Director (Dec. 1994) (on file with the author).

n113 *Id.* (emphasis added).

n114 *Drug Availability Hearings, supra* note 79, at 15-16 (statement of Admiral Robert Kramek) (emphasis added).

n115 *Id.* at 16.

n116 *Drug Availability Hearings, supra* note 79, at 69 (testimony of Robert Kramek).

n117 *Id.* at 18.

n118 Letter from Commissioner of U.S. Customs George J. Weise to Admiral Robert Kramek (Dec. 19, 1995) (on file with the author).

n119 *Id.*

n120 *Effectiveness Hearings, supra* note 5, at 142 (testimony of Lee Brown).

n121 *Id.* at 143-44; *see generally id.* at 140-81.

n122 *Id.* at 151.

n123 GENERAL ACCOUNTING OFFICE, DRUG WAR: OBSERVATIONS ON THE U.S. INTERNATIONAL DRUG CONTROL STRATEGY 5 (1995) [hereinafter U.S. INTERNATIONAL DRUG CONTROL STRATEGY].

n124 *Effectiveness Hearings, supra* note 5, at 60 (statement of Lee Brown).

n125 GENERAL ACCOUNTING OFFICE, DRUG CONTROL: U.S. HEROIN PROGRAM ENCOUNTERS MANY OBSTACLES IN SOUTHEAST ASIA 23 (1996).

n126 *See* U.S. INTERNATIONAL DRUG CONTROL STRATEGY, supra note 123, at 10-11.

n127 *See, e.g., Effectiveness Hearings, supra* note 5, at 142 (statement of Lee Brown).

n128 NATIONAL DRUG CONTROL POLICY, 1995, *supra* note 13, at 44.

n129 A Presidential Decision Directive is a written policy declaration, signed by the President, which directs Executive Branch departments and agencies to follow a particular policy course. It is usually issued in concert with implementing instructions.

n130 NATIONAL DRUG CONTROL POLICY, 1995, *supra* note 13, at 44.

n131 *Id.*

n132 U.S. INTERNATIONAL DRUG CONTROL STRATEGY, *supra* note 123, at 8.

n133 *Id.* at 4.

n134 *Id.* at 2.

n135 *Id.* at 7.

n136 *Id.* at 8.

n137 *Id.* at 8-9.

n138 *Id.* at 9.

n139 REAUTHORIZATION, *supra* note 28, at 68.

n140 *Id.*

n141 *Id.* at 68-69.

n142 Unclassified After Action Report of ONDCP/USSOUTHCOM Counterdrug Conference §§ 3-2, 3-3 (1994) (on file with the author). Among the other constructive, forward-looking recommendations in this largely overlooked *After Action Report* are the following: "ONDCP should develop a coherent and consistent message to Congress and the American people regarding the relationship of drugs to violent crime . . . ."; "provide senior Administration leadership . . . sufficient authority to identify and delegate responsibility to a regional planning coordinator in the field . . . ."; "consider options for a Drug Summit this fiscal year . . . ."; "create a better relationship with Congress through a more consistent budget package [and] speak with a single voice to Congress and be prepared to present a clear set of effectiveness measurements;" "develop an implementation plan that realistically can persuade our allies that the drug fight is in their interest . . . ."; consider "focus[ing] on critical nodes like the center of gravity, Peru . . . ."; "emphasize training [and] use Special Forces as a multiplier to train host country forces;" "establish a lead person in each Country Team with the authority to coordinate all resources [and] seek support from other countries [and,] for example[,] request the European militaries to contribute material and personnel support to the counter-drug effort;" "develop a budget that is threat-driven as opposed

to program-driven . . . ."; "more consistent budget review . . . ."; "reinforce effective programs;" "negotiate an investment treaty with countries in return for stopping drugs"; "assist in strengthening judicial institutions in Latin America;" and devise a "regional action plan that governs the actions and resources of all agencies in a coordinated and coherent fashion . . . ." *Id.* Notably, the author of this 1994 report was the U.S. Southern Command leader, General Barry McCaffrey, now the U.S. "Drug Czar." In this single fact, there is a measure of renewed hope that the United States will again play a prominent role in counter-narcotics efforts in both source and drug transit countries.

n143 JIATF East was created by Presidential Decision Directive 14 (PDD 14), which ordered a review of the nation's counternarcotics command and control intelligence centers. Creation of three joint interagency task forces and a domestic air interdiction center was authorized by the White House Drug Czar in April 1994. Accordingly, JIATF East is joined in its interdiction mission by JIATF West in Almeda, California; JIATF South in Panama; the DAICC at March Air Force Base, California; and JTF-6 in El Paso, Texas. *Id.*

JIATF East is dedicated to "deconfliction of all non-detection and monitoring counter drug activities in the transit zone." The command integrates intelligence with operations, and "coordinates the employment of the U.S. Navy and U.S. Coast Guard ships and aircraft, U.S. Air Force aircraft, and aircraft and ships from allied nations, such as Great Britain and the Netherlands." The command's mission boils down to "maximiz[ing] the disruption of drug transhipment," collecting, integrating and disseminating intelligence, and guiding detection and monitoring forces for tactical action. *Id.*

Just as importantly, JIATF East integrates law enforcement personnel, primarily from Customs, into the international interdiction effort. For that reason, the command includes FBI, DEA, DIA and State Department, in addition to the Department of Defense.

n144 *Clinton's Drug Policy Perceived as Retreat*, STAR TRIB., Feb. 14, 1993, at 1.

n145 *See Effectiveness Hearings, supra* note 5, at 140-44 (testimony of Lee Brown).

n146 *Drug Availability Hearings, supra* note 79, at 69 (testimony of Robert Kramek).

n147 *See Effectiveness Hearings, supra* note 5, at 19, 22 (testimony of John P. Walters). *See also* DRUG POLICY FOUNDATION, THE DRUG WAR AND CLINTON'S POLICY SHIFT (1994).

n148 For example, the Greater Antilles Section Coast Guard Base ("GANTSAC") in Puerto Rico must cover 1.3 million square miles, and would benefit enormously from the creation of a seamless web of bilateral agreements with nations in the region, as well as some working arrangement with Cuba. According to field agents who participate in the areas' interagency working group, approximately 84 metric tons of cocaine arrives in Puerto Rico annually, of which "we interdict 10 to 15 percent."

n149 LOSING GROUND, *supra* note 86, at 9.

n150 Agents participating in Operation Bahamas, Turks and Caicos ("OPBAT"), a multi-agency, international operation based in Nassua, Bahamas, stated on a recent trip to the region that they have lost major assets and personnel over the past two years with an obvious detrimental effect on operations.

OPBAT's mission is to halt the flow of cocaine and marijuana through the 700-island Bahamian region to the United States. At present, in an effort to achieve this aim, OPBAT operates three widely dispersed helicopter bases, from which U.S. Coast Guard and DEA helicopters are dispatched on cue from tracking by the JIATF-East or DAICC. Since the helicopters must operate in foreign waters, they are piloted by personnel from either the Government of the Bahamas or Turks and Caicos Island police, who are in turn responsible for making ar-

rests and seizures. A United States DEA agent is, however, expected to be on every flight to coordinate intelligence and provide additional advice.

The Clinton Administration's decision to remove and destroy the aerostats based in the Bahamas, which was perceived as allowing a transfer of personnel, has instead had a negative effect on interdiction capability. *See* NASSAU COUNTRY OFFICE, *supra* note 91, at 7-8.

n151 *Id.* at 10.

n152 This last implication, while not discussed above, is evidenced by clear congressional concern. Representative Ben Gilman (R-N.Y.), for example, recently noted that the President's de-emphasis on ONDCP has had negative implications. "Regrettably . . . [the White House is] sending the wrong signals to our Latin and Caribbean allies." ROBERT B. CHARLES, DRUG POLICY FOUNDATION, THE DRUG WAR AND CLINTON'S POLICY SHIFT 6 (1993). Similarly, Judge Bonner has publicly noted that: "[The] deep cut in ONDCP has symbolic significance not only in Washington . . . but around the world. Our foreign allies read it as a signal that the Clinton Administration is backing away from a strong commitment to drug control policy." *Id.* at 8.

n153 *See generally Effectiveness Hearings, supra* note 5, at 18-39.

n154 *Effectiveness Hearings, supra* note 5, at 49 (testimony of William J. Bennett).

n155 *Id.* at 109 (testimony of Paul A. Yost).

n156 *Id.* at 109-15 (testimony of Thomas Hedrick).

n157 *Id.* at 122-24 (testimony of G. Bridget Ryan).

n158 *Id.*

n159 *Effectiveness Hearings, supra* note 5, at 124-28 (testimony of James Copple).

n160 *Id.* at 13-16 (testimony of Nancy Reagan).

n161 *Id.*

n162 *Id.* The letter poignantly described how this girl of low self-esteem got caught in the "vicious cycle" of drug use, prostitution to get more drugs, and the death of her deformed and premature baby. The letter ended with a plea, which Nancy Reagan reiterated: "'Please reach kids my age and younger. Don't let what has happened to me and what destroyed my life happen to them.'" *Id.* at 14.

Reagan also testified that, "before the drug use increases of 1993 and 1994, we really had seen marked progress," and that "[juvenile] attitudes were being changed." She credited many elements of society, including "athletes and entertainers" and "many CEOs of large companies" for this decrease. *Id.*

She also explained the origins of her "Just Say No" message; it came in answer to a child's question about what to do if pressured to buy or use drugs. As she explained, it was an intentionally simple answer, and was never designed to be the "total answer." In short, Mrs. Reagan said, it is "important for children to appreciate that 'no' is in the vocabulary . . . ." *Id.*

n163 *Id.* at 15.

n164 *Id.* Overall, Reagan argued for greater attention to demand reduction. However, she also testified that "many outstanding prevention programs across the country" were "started and funded privately," including her own foundation, which recently "merged with the BEST Foundation for a Drug-Free Tomorrow" and "has trained over 13,000 teachers and others." *Id.*

Beyond the private sector, she said, the anti-drug effort "requires leadership here in Washington." Rhetorically, she asked, "where has [the leadership] gone?," and in closing, she called for renewed leadership on this issue. "Today, the anti-drug message just seems to be fading away. Children need to hear it and hear it often, just like they need to hear that they're loved." *Id.* Missing is "a sense of common national purpose" in combating drugs and teaching young Americans to "live in the world that God made, not the nightmare world of drugs." *Id.* at 16.

n165 *See supra* notes 122-123.

n166 *Effectiveness Hearings, supra* note 5, at 158 (testimony of Rep. Ileana Ros-Lehtinen).

n167 Brown, for example, admitted that, "clearly, as in the case of many programs, there are abuses." *Effectiveness Hearings, supra* note 5, at 160.

n168 *See id.* at 158-60.

n169 *Id.* at 159-60.

n170 *Id.* at 160.

n171 *Id.* at 161.

n172 *Id.* at 158-61.

n173 *Id.* at 158-59.

n174 *Id.* at 159.

n175 *Id.* at 161-63. Brown's only reply was that he was "far from being hypocritical" and that it was his "responsibility" to address "areas where we need improvement." While noting that there may be "some abuses in the program," he saw deep cuts in the program as inappropriate. *Id.* at 163.

n176 *Effectiveness Hearings, supra* note 5, at 43-44 (testimony of Judge Bonner).

n177 *Id.* at 44.

n178 *Id.*

n179 Notable exceptions to this statement are the President's late-1995 speech to the United Nations, which addressed international crime and illegal drug trafficking; the President's "Remarks to the National Leadership

Forum of Community Antidrug Coalitions," on November 2, 1995; and the President's January 1996 State of the Union Address, in which crime and drugs were mentioned.

n180 *See* Zeliff, *Missing Leader in the Drug World, supra* note 57.

n181 *Effectiveness Hearings, supra* note 5, at 57 (1995) (testimony of Lee Brown).

n182 *See, e.g.*, LOSING GROUND, *supra* note 86, at 6. Federal treatment spending was $ 505.6 million in FY 1982, yet in 1995 federal treatment spending topped $ 2.65 billion. *See* OFFICE OF NATIONAL DRUG CONTROL POLICY, THE NATIONAL DRUG BUDGET SUMMARY, *supra* note 94, at 238. In President Clinton's FY 1997 budget request, while prevention, interdiction and international programs each remain roughly $ 100 million below their highwater marks in the early 1990s, treatment funding hits a record $ 2.9 billion. *See supra* note 59.

n183 *Effectiveness Hearings, supra* note 5, at 44 (testimony of Robert C. Bonner). Bonner also noted: "Despite its attraction, treatment, as most experts will candidly acknowledge, is not the be-all-and-end-all." *Id.*

n184 *Id.*

n185 *Id.*

n186 John Walters, for example, testified: "Most addicts have been through treatment more than once. The harsh fact is that drug addicts like using drugs . . . . They sometimes admit themselves to treatment programs, not to stop using drugs, but to regain greater control over their drug use." *Effectiveness Hearings, supra* note 5, at 29 (statement of John P. Walters). Walters cited leading studies. *Id.* at 30 (citing Yih-ing Hser, et al., *A 24-Year Follow-up of California Narcotics Addicts*, 50 ARCHIVES GEN. PSYCHIATRY 577 (1993)).

n187 *Id.* at 22.

n188 1994 PRELIMINARY ESTIMATES, *supra* note 19.

n189 *See Effectiveness Hearings, supra* note 5, at 26-29.

n190 *Id.* at 22.

n191 *Id.* at 29.

n192 C. PETER RYDELL & SUSAN S. EVERINGHAM, RAND DRUG POLICY RESEARCH CENTER, CONTROLLING COCAINE: SUPPLY VERSUS DEMAND PROGRAMS (1994) [herein-after RAND STUDY].

n193 *Effectiveness Hearings, supra* note 5, at 57 (testimony of Lee Brown).

n194 *Id.* It is also featured prominently in President Clinton's FY 1997 request for record levels of treatment funding. *See supra* note 59, at 27.

n195 On legalization, the RAND study notes the devastating effect that drug legalization would have on use, through the economic mechanism of reduced prices, or price elasticity. In 1994, the average street or retail price for a pure gram of cocaine was $ 143; if cocaine were legalized, the estimated retail price would be $ 15-20 per gram. RAND STUDY, *supra* note 192.

n196 CHRISTOPHER SCHNAUBELT, NATIONAL INTERAGENCY COUNTERDRUG INSTITUTE, DRUG TREATMENT VERSUS SUPPLY REDUCTION: WHICH IS CHEAPER? 2 (1995).

n197 *See, e.g.*, JAMES E. BURKE, AN OVERVIEW OF ILLEGAL DRUGS IN AMERICA (1995).

n198 *See* NATIONAL DRUG CONTROL POLICY, 1995, *supra* note 13, at 20.

n199 RAND STUDY, *supra* note 192, at 24-25, 88-89.

n200 *See supra* notes 36-43 and accompanying text.

n201 *See Effectiveness Hearings, supra* note 5, at 43-44 (testimony of Robert C. Bonner). *See also id.* at 26-30 (testimony of John P. Walters).

n202 *See Effectiveness Hearings, supra* note 5, at 61 (testimony of Lee Brown).

n203 Califano and Bennett Press Release, *supra* note 23. *See also* Joseph A. Califano, *It's Drugs Stupid*, N.Y. TIMES, Jan. 29, 1995, § 6 (magazine), at 40.

n204 ONDCP bears "responsibility to monitor and oversee drug control efforts by federal agencies." REAUTHORIZATION, *supra* note 28, at 48. *See also* 21 U.S.C. § 1504 (1994).

n205 Note, however, that efforts to increase ONDCP budget authority in the Violent Crime Control Act of 1994 resulted in the award to ONDCP of discretion to shift up to two percent of the Nation's counternarcotics budget from one agency to another. Although this authority carried the symbolic suggestion that ONDCP had some genuine leverage over departments and agencies, the FBI and other agencies were successful in further marginalizing ONDCP's budget authority. Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322, 108 Stat. 1796 (1994).

n206 GAO has reported a number of examples in which early presidential intervention would have provided ONDCP with missing authority, and likely prevented future inter-agency disputes. For example, GAO reported in 1993, that: HHS officials believed ONDCP's request to "review . . . RFAS [HHS' Requests for Applications for drug treatment and prevention grant monies] for three grant programs and disagreements that resulted from these reviews were a serious source of conflict between ONDCP and HHS." Likewise, GAO reported that when ONDCP attempted to assert its "overall authority to oversee implementation of the national strategy," it was often accused of "micromanagement." In the same vein, "disagreements between ONDCP and HHS over timeliness and quality of drug data have been a problem for the two agencies and have also contributed to strained working relationships." REAUTHORIZATION, *supra* note 28, at 48-49, 51. Perhaps most disturbingly, when ONDCP sought "implementation plans" from the federal agencies involved in executing ONDCP's 400 objectives contained in the National Drug Control Strategy, ONDCP was effectively rebuffed. ONDCP's Director wrote that development of these implementation plans was "the critical step in turning the words of the National Drug Control Strategy into programs that reduce drug use in this country," yet compliance was minimal, since "ED [the Department of Education], DoJ and HHS officials disagreed about the utility of ONDCP's requirement

that agencies develop implementation plans for objectives identified in national drug control strategies" and found the requirement "burdensome and of little value." *Id.* at 50.

n207 For example, a strong personality in the role of ONDCP director, combined with a strongly held priority by the sitting president, appears to produce a stronger and more effective policy than the alternative. These variables, which also affect the willingness of agency and departmental heads to cooperate with the ONDCP director, are non-institutional. On the positive side, the recent appointment of four-star general Barry McCaffrey to White House Drug Czar offers new hope that change may follow. One April 1996 institutional change that could also make an operational difference, and could strengthen both support and coordination, is the announced establishment within the National Security Council of the Global Organized Crime Committee.

n208 REAUTHORIZATION, *supra* note 28, at 48-50.

n209 *Id.* at 51.

n210 The four remedies suggested by the absence of meaningful ONDCP budget authority are: (1) substantially increased ONDCP budget authority; (2) a wholesale shift of demand side (if not also supply side) coordination authority out of ONDCP to a Secretary, Undersecretary or Assistant Secretary at the agency with chief budget authority (likely eliminating the need for ONDCP); (3) shifting both budget authority and coordination responsibility to a different agency altogether (e.g., all demand reduction programs from HHS and DoED to an independent agency at DoJ that operates similarly to DEA); or (4) making no institutional change but insisting that the President clearly, strongly and consistently support the decisions of his White House Drug Czar and ONDCP.

n211 *See Effectiveness Hearings, supra* note 5, at 142-44 (statement of Rep. Zeliff).

n212 "Between 1993 and June 1995, the transit zone 'disruption rate' -- the ability of U.S. forces to seize or otherwise turn back drug shipments -- dropped 53 percent, from 435.1 kilograms per day to 205.2 percent kilograms [according to JIATF-East]." *See* LOSING GROUND, *supra* note 86, at 13.

n213 One report summed up frustration this way: "The trade-off for cuts to the transit zone interdiction forces was to have been a 'new' concentration on institution-building and interdiction in the source countries of Latin America . . . . More than 18 months after unveiling the new strategy . . . the shift had not taken place." *Id.*

n214 *See generally* U.S. INTERNATIONAL DRUG CONTROL STRATEGY, *supra* note 123, at 2, 4, 8.

n215 *Id.* at 7.

n216 There are also indications that "one in three juvenile detainees were under the influence of drugs at the time of their offense." RAND STUDY, *supra* note 192, at 64-65.

n217 Record keeping, for example, under the Safe and Drug Free Schools and Communities Act of 1994, 20 U.S.C. §§ 7101-7105 (1994), by states and the Department of Education has been questioned and appears to have been often incomplete. The National Commission on Drug Free Schools recommended, after extensive study that: "The Department of Education should monitor closely the development and enforcement of school and college antidrug policies [and] . . . should ensure that schools conduct periodic evaluations of all drug education and prevention programs." NATIONAL COMMISSION ON DRUG FREE SCHOOLS, TOWARD A DRUG-FREE GENERATION: A NATION'S RESPONSIBILITY 79 (1990).

n218 One such option was circulated by Representative Barton (R-Tex.) in early 1996, and suggested a reconfiguration of the counternarcotics effort, assigning major new authority to an independent and consolidated federal counternarcotics agency. The aim of that bill is to "consolidate within a single Federal agency Federal programs and functions relating to services for the prevention and treatment of substance abuse." Draft of proposed bill entitled "Drug Abuse Prevention Act of 1996" (February 1996) (on file with the author). While still under discussion, this thoughtful effort might well increase certain efficiencies and streamline the relevant chains of command. It is also likely to engender considerable agency and departmental opposition, since many agencies and program administrators likely believe that they could -- if so directed -- more effectively coordinate within the current counternarcotics structure. The Barton proposal, however, which has strong support from some sectors of the drug prevention community, is important and worthy of further consideration.

n219 Pessimists, or those who do not realize how effective past, coordinated counternarcotics efforts have been, gravitated to a bill offered by Senators Richard Shelby (R-Ala.) and Bob Kerry (D-Neb.), which would have eliminated the White House Drug Czar and ONDCP. While this measure died, it was likely to have been counterproductive. One valuable political asset in the drug war is the Drug Czar's cabinet rank, and another is the ONDCP's independent authority to garner attention from the President, Congress and other opinion leaders.

n220 *See Correction: Prison Sentence*, UNION LEADER, Dec. 5, 1995, at A3.

n221 *See* GENERAL ACCOUNTING OFFICE, DRUG USE MEASUREMENT: STRENGTHS, LIMITATIONS AND RECOMMENDATIONS FOR IMPROVEMENT 2-3, 5, 58-60, 68-69 (1993).

n222 *Id.* at 5.

n223 The June 1993 GAO report stated that: "Although recognizing the need for further scientific study of hair analysis, we [GAO] endorse its field trial use in community drug prevalence measurement studies for the following reasons: (1) multiple independent studies have demonstrated that illicit drugs can be detected in the hair, (2) National Institute of Standards and Technology tests have demonstrated that laboratories can identify drug residues in hair specimens with a high rate of success, (3) the Federal Bureau of Investigation chemistry and toxicology laboratory has been working with illicit drugs regularly for several years and has not found passive exposure or environmental contamination to be a practical concern for cocaine, (4) NIDA's Division of Epidemiology and Prevention Research proposed that exploratory hair testing be adopted in the 1992 NHSDA, (5) several prominent laboratory and social science drug researchers have endorsed self-report validity testing using hair analysis, and (6) a Food and Drug Administration official saw no problem in conducting exploratory self-report validation research studies, as long as specific radioimmunoassay (RIA) hair kits were used and the information derived was not used for product marketing and clinical assessments." *Id.* at 59.

n224 *See, e.g.*, Elijah Gosier, *Drug War's More Than Photo Op.*, ST. PETERSBURG TIMES, June 27, 1994, at 1.

Mr. JORDAN. Thank you, Mr. Chairman.

Let me go right to you, Mr. Charles, because actually I have to run here in about 3 minutes.

Your No. 4 point, you were really strong on talking about why we should not have any decriminalization of drug use. You said more drugs means more addiction. It makes sense to me. Just elaborate on that point if you would, and then I have one other question.

Mr. CHARLES. The nutshell version is you can talk to Herb Clever up at the Columbia University Substance Abuse Center. The research is pretty clear. When you have more availability and more use, you get a percentage increase in addiction. Over years, that becomes an increasing problem, because you get more and more sick people.

Mr. JORDAN. Right. Give me your comments then on the needle exchange program.

Mr. CHARLES. Needle exchange programs, on which there is a lot of divided research, basically don't do what they are credited for doing. The reason for that is the word "exchange" actually is a bit of a fiction. It is really a needle giveaway program. Because addicts, and you can talk to the addicts themselves, tend to get themselves in a position where they want the drug. So heroin happens to be a very addictive drug. Other intravenous drugs are usually high potency. The result is that they don't go back and exchange the needles. So there is more and more needles out there. Never mind the moral message that you are sending, which is somehow drug abuse by injection is OK.

Mr. JORDAN. Give me again, Mr. Charles, your background. You worked for both R&D, Republicans and Democrats, you worked for both here?

Mr. CHARLES. I have worked for Mr. Cummings quite a lot over the years, as people know. My background is I have a graduate degree in both economics and law. I litigated. I worked in the Reagan and Bush White Houses. I then became a litigator, worked writing a bunch of these things, and then taught at Harvard for a short period of time, became a Staff Director for Speaker Hastert, ran the drug task forces, and then later wrote a book on narcotics, and worked for Colin Powell.

Mr. JORDAN. One of the other points you made in your testimony, and just for the remaining few minutes I have here, the link between terrorists and drug use, I think you named off every terrorist group I have ever heard of, I believe.

Mr. CHARLES. Actually, there are ones I didn't name.

Mr. JORDAN. The ones I have heard of at least. Talk about that link and the impact of interdiction efforts in dealing with that link-up between drug use and terrorist activity.

Mr. CHARLES. There is another elephant in the room, and that other elephant in the room is the very tight relationship that exists worldwide. And in the United States talk with some of the HIDTAs about ongoing investigations into Hezbollah in the United States. Talk to the HIDTAs. They will tell you.

There is a very clear link between drug funding and the growth of terrorist organizations of all kinds and criminal, larger international criminal organizations. The terrorist organizations, believe

it or not, that we worry most about, and I won't detail them, although Hezbollah happens to be the largest terrorist organization in the world, they are increasingly dependent on drug revenue. And what you find is, and this is your job as a Congressman, not mine, is that there is a great stovepiping which creates the elephant in the room, and nobody wants to talk about the drug-terror nexus.

The great stovepiping is that DEA, God bless them for everything they do, deals with just drugs, and CIA and others in the intelligence community tend to focus their resources on CT. In fact they have bled dry the CNC component of CIA in order to do CT work. Nobody wants to talk about the other part of this. And the reality is that in the quiet of the night, while we do not have proof beyond a reasonable doubt that every organization is getting the majority of its funding from drugs, we have more probable than not, and if we wait for proof beyond a reasonable doubt, we'll be looking down the barrel of another 9/11.

Mr. JORDAN. Mr. Charles, one of the reasons, if you were here for the earlier testimony with the Director, I asked him about how he interfaces with Homeland Security in trying to address this very pint.

Mr. CHARLES. Point-blank, there was a statutory provision which was put in by Mr. Souder and Mr. Cummings that allows him to interface directly with DHS through the CNE office. It has essentially been an unutilized office. And what you have now is some hope, and I will tell you why. In addition to—and you are hearing this from a Republican.

I am not only hopeful because they have put back a lot of the money on law enforcement, they have put back a lot of the money for critical things you need, but you have Rand Beers, who is an all-time drug warrior, a guy that ran INL, a $2 billion bureau that I ran for Powell, he ran it before me, and that person, Rand Beers, I think is now the No. 2 or No. 3 at DHS. He cares.

Mr. JORDAN. But this ability, this is so important and I am hoping the chairman here is going to look into this more as well, this ability for this office that we are talking about today, Mr. Kerlikowske's office, to interface with Homeland Security, that is critical.

Mr. CHARLES. It is critical, because there is no doubt in my mind nor in the mind of any serious law enforcement officer in this country that looks at CT-CN issues, that is counterterrorism-counternarcotics, that the link is intimate.

Mr. JORDAN. Mr. Chairman, again, I hope that is something we can really delve into in the future because of the importance for national security.

Mr. KUCINICH. Thank you very much.

Mr. Charles, given your position in 2003 to 2005 as Assistant Secretary of State for International Narcotics and Law Enforcement Affairs, do you have any theory as to how it is that during the U.S. presence in Afghanistan, the production of opium shot up 80 to 90 percent? Do you have any theory about that?

Mr. CHARLES. I have more than a theory. I have the facts.

Mr. KUCINICH. How did that happen?

Mr. CHARLES. There were a number of people, like me, Rich Armitage and Colin Powell, who argued very strongly that counter-

narcotics should be a piece of the mission, that ultimately the better part of the funding for the Taliban and even remnants of al Qaeda and IMU and HIG that were active in Afghanistan and surrounding areas, that the better part of the fuel was all drug money.

The basic argument was that if you want to stop a combustion engine, you don't keep poking your fingers into it and trying to catch individual terrorists, which is what we were doing. You do that in combination with cutting off the fuel for the engine. And what we did not do, what we never implemented because we were not allowed to fully implement it, was a counternarcotics strategy.

I wrote 13 different counternarcotics strategies at the behest of the NSC. Every single one of them got a nice read, and that was where it ended.

Mr. KUCINICH. You are talking about specifically with respect to Afghanistan?

Mr. CHARLES. I am talking about specifically with respect to Afghanistan.

Mr. KUCINICH. This subcommittee would be happy to read those reports.

Mr. CHARLES. Well, I will tell you, the better part of that strategy still sits on the table over at State.

Mr. KUCINICH. I think the American people, who are sending their sons and daughters to Afghanistan, and we have lost quite a few men and women there, and we have seen the Taliban in resurgence for quite a while, and you have testified that these organizations are being fueled with drug money, and we have seen there has been an 80–90 percent increase in opium production, and then, of course, we are talking about an increase in heroin sales. If there is that link there, that is something we ought to explore, especially since you said that a critical part of the strategy was left out.

Now, Mr. Reuter, do you have any comment on that at all?

Mr. REUTER. Yes. I mean, if in fact there were——

Mr. KUCINICH. Is your mic on, sir? If not—if it is——

Mr. REUTER. It is on.

Mr. KUCINICH. Pull it closer so we can hear you.

Mr. REUTER. OK. Sorry.

If there were in fact a strategy that could reduce opium production without imperiling the Karzai government, then indeed this government should undertake that. No such strategy has been proposed.

Mr. CHARLES. I beg to differ.

Mr. KUCINICH. Hold on, Mr. Charles. I will ask the questions and you will direct your comments to the Chair.

Are you saying then that the Karzai government is actually being supported by the increased opium production?

Mr. REUTER. The effort to eradicate crops in the field is an action against peasant farmers in Afghanistan. They are politically important simply because they are large in number, not because they are particularly well organized.

The reason that the military, not just of the United States but the military of other countries present in the coalition forces as well, have been resistant to implementing any of these programs is precisely the perception, and I think a perfectly plausible one, that this would in fact endanger the central government that we

have helped form. And it is that tension which is at the heart of the fight between the State Department and Defense Department.

Mr. Charles has a view about that, and others disagree with it, but that is the tension, and there isn't any way that I think sitting out here we can resolve it. But it is clear that if we push—let me just say one more thing.

One of the things we can do is push production out of areas which we control into areas the Taliban controls, and that I think, if anything, worsens the problem inasmuch as it increases the funding base of the Taliban.

Mr. KUCINICH. I am going to go to you in a minute, Mr. Charles. I just want you to respond to this question, Mr. Reuter.

How do you explain that with the U.S. military having such a large presence in Afghanistan, that during the same period of time we see such a rapid increase in opium production? How does that happen?

Mr. REUTER. OK, let me make two comments about that. First is about the rapid increase. Essentially after 2002, the levels of production returned to where they had been before the Taliban had imposed a ban in the year 2001. So until 2005, it was just back to where it was before. I think the estimates for 2006 and 2007, which show very large increases, are quite implausible. There is no evidence in terms of the decline in price in Afghanistan or increased availability in the rest of the world that there has been a very large increase. So I am quite skeptical of those figures.

Nonetheless, your question is probably reasonable even without those increases. It is clear that the crop is grown openly through much of the country. It gets moved around. There have been times in which provinces have been cleaned up and it moved elsewhere. That is indeed what our policies can do. We can move it around. But we do not have the control on the ground to be able to accomplish it.

Mr. KUCINICH. Thank you, Mr. Reuter.

Mr. Charles.

Mr. CHARLES. With all due deference, the numbers were in the tens of thousands prior to the Taliban locking it down in 2001. They went to 30,000 in 2002, 61,000 in 2003, 214,000 in 2004, and more than that in 2005. Yes, they are higher now in 2006 and 2007. Your numbers are exactly right. They supply more than 90 percent of the world market.

And are they accurate? Well, both the commercial and closed satellite photography seem to suggest they're highly accurate, No. 1. No. 2, there is a strategy. The strategy is a combined strategy. It is a strategy that has worked in other countries around the world for 30 years, and it involves putting alternative development hand in glove with eradication that is effective.

And Mr. Cummings' point about effectiveness is so valuable. Getting at it one by one, region by region. And by the way, the crop does not move around dramatically. To a large extent the north of Afghanistan has never been a big poppy growing area except for parts of Badakhstan. But in the provinces that are most heavily populated now by the Taliban drugs are the primary driver of income for that group. And the saddest part about this is this is an utterly winnable effort. If we would sit down, look again at the

strategies that were put forward by Colin Powell, by Rich Armitage, by me in a prior administration that were essentially sidelined because they were too—here is the real bottom line. And I'm really going step on some toes here. When the field commander who happens to now be the Ambassador was in charge over there they took the view, they took the view that this was highly inconvenient, that essentially handling——

Mr. KUCINICH. What was highly inconvenient?

Mr. CHARLES. Addressing the drug issue was highly inconvenient. You could put it down there in a social category like hepatitis and deal with it later. The problem is anybody who knows counternarcotics, anybody at this table, most of the people in this room, know that it is an enormous accelerant of instability when it's allowed to go just roughshod over society. And so what transpired was every military commander—I spent 10 years in the military, every military commander has a 2-year tour, give or take, and they know that it can auger in after they leave. So it was too hard a problem to address at that time, and at the end of the day we are now paying for inactivity, we are now paying the price for not having tackled it at the front end.

And I testified in front of this committee 5 years ago saying identical things to what I'm saying now, and I got my knuckles wrapped when I went back. But the bottom line is I always told the truth, and I'm telling you the truth now. It's winnable, but we're not doing it.

Mr. KUCINICH. I want to say to Mr. Charles and Mr. Reuter that this paradox of increased U.S. presence in Afghanistan and sharply increasing production of opium and therefore heroin, where Afghanistan, according to figures by our own government, is achieving a larger and larger market share worldwide, there's something wrong with that story. And what we need to do——

Mr. CHARLES. Can I tell you what it is, sir?

Mr. KUCINICH. No. What we are going to need to do is to talk to the full committee, talk to Mr. Towns about looking at this again and get some resources in so we can have a more penetrating analysis. As I've been following this Iraq war, to me it's been, or the Afghanistan war, it's been mystifying how we could see such a sharp increase.

Mr. CHARLES. Sir, at the end of the day——

Mr. KUCINICH. Thank you, Mr. Charles. You just explained one possibility, and I appreciate the mitigating circumstances that Mr. Reuter brings up.

I'm going to move on to another part of the question here to Ms. Christopher. The NAPA report suggests that it is critically important that ONDCP be a data driven organization seen by other drug control agencies as an honest broker of drug use trends and other data reflecting successes and failures of drug control policy. For example, NAPA is critical of ONDCP's focus on marijuana as a gateway drug, associating early marijuana use with addiction to other drugs later in life since there is data showing that there are other gateway drugs that are more associated with leading young people to greater drug use than marijuana. If a drug prevention policy would be based on science, should we be focusing more on teen use

of alcohol and tobacco, and how can ONDCP present data in a more neutral and legitimate manner?

Ms. CHRISTOPHER. Thank you for the question, Mr. Chairman. The NAPA report does emphasize the importance of a more collaborative and outreached, focused strategy, and we believe that the current Director has made proactive steps in addressing that particular issue. And certainly the limited focus on marijuana does negate or not pay enough attention to the role of alcohol, and tobacco for that matter, in leading young people to more extensive use of other drugs.

So we definitely encourage a broader scientific and evidence base to inform the overall policy, and we encourage a comprehensive strategy that looks at all of the issues that are before the committee today.

Mr. KUCINICH. Thank you.

Mr. Carnevale, can you explain your proposal for a modified budget certification process and how you think the budget should be structured to ensure that Congress and the public are aware of all drug policy spending?

Mr. CARNEVALE. Yes. This is one area, Mr. Chairman, I think that's very critical. Budget certification is a tool that the Office of National Drug Control Policy has to help it shape budgets that the Federal—its Federal agency partners put together during the year before OMB sees it. Certification was reviewed by the General Accounting Office back in 1999, and they looked at a decade's worth of effort with respect to the certification process and found that the tool was highly effective even though we had only, in quotes, decertified about 10 agencies over the entire 10-year period. If certification is used correctly, then what you do is put peer pressure, in a sense real pressure because you're speaking from the White House, on your partner agencies to in fact do what the President wants, which is to support the President's National Drug Control Strategy.

So in terms of the process, there's two things I would like to suggest. One is under current law certification the tool itself has been badly damaged I think. Every time ONDCP certifies a budget it now has to report to Congress. And so what that results in is a fear to use the tool itself because Congress can disagree with ONDCP as it's trying to manage the budget process.

But setting that aside, I think in terms of improving the process there's been a dramatic change, as the NAPA report correctly finds, in how we account for drug control spending. ONDCP under the previous administration threw out about 30 agencies, I don't have the exact number, out of the drug budget, and so these agencies are no longer being reviewed for purposes of certification. I think one of the recommendations that I have is that we bring these agencies back into the comprehensive accounting that NAPA talked about in its report. That's No. 2.

But with certification, I have sort of a lengthy explanation in my testimony, but I can now envision a two-tier process where a handful of agencies get certified. And these agencies would be the ones that have a very active role in making policy work. For example, thinking about treatment, thinking about prevention, prosecution, investigations, these are areas where you can put resources in and

have an immediate effect. When you start thinking about the Bureau of Prisons, which houses—well over 50 percent of its incarcerated population is in there for drug-related reasons, we no longer score them or treat their budgets as drug related. But in a policy sense I would argue that part of that makes sense. In a second tier you wouldn't decertify or certify that budget because the Bureau of Prisons can't actively through policy decide 1 day it's going to increase its prison population to 80 percent drug related. And so we've proposed a two-tier approach to the certification process in our testimony, or in my testimony.

Mr. KUCINICH. Thank you. Now, your testimony states that while drug use among youth has been on a general decline since 1996, data shows softening attitudes related to disapproval of drug use which could result in the beginning of an upward trend. You also cite an uptick in the 8th and 12th grade use of illicit drugs from 2007 to 2008.

Given this data and the general decline of resources allocated to prevention in the last 8 years, isn't the proposal to eliminate the States' grants portion of the safe and drug free schools and communities program shortsighted? Are you concerned that if drug use rates rise without this program there will be no safety net in place to deal with, and shouldn't we be putting more, not less resources into prevention programs.

Mr. CARNEVALE. My answer to the shortsighted part of the question is yes, I think it is shortsighted. I'm very concerned. I looked at the Department of Education—excuse me—the Office of Management and Budget's recommendation clearly, and there's a Department of Education report about the program, and it doesn't say the program doesn't work, the States' grant portion, the State portion of the program. But what it does say is that the program has been badly mismanaged, and it has been for the past decade. And I'm greatly concerned that OMB in this case is using that information to cut a program simply because it's been mismanaged. I would rather see I think at this point, given what we're seeing with attitudes changing, and these attitudes have to do with the softening of attitudes with respect to the disapproval rates around drug abuse, the dangers of drug abuse, we're seeing upticks now that aren't statistically significant. But we saw this happen back in 1990, 1991 and 1992, when suddenly youth drug use exploded and all the tell-tales were there.

I'm really concerned that this program be saved. If the issue is one of mismanagement, which I think is a strong tradition at the Department of Education, but it has been one that cut across many administrations, then I think it's time that we take the funding for this program and have it transferred to ONDCP and let them decide which agencies can best use that funding.

Mr. KUCINICH. Thank you, sir. Mr. Reuter, did you have a comment on that?

Mr. REUTER. I'm co-author of the report that was cited as a basis for cutting the program. That was a report done in 2001 and perhaps things have changed. But at the time I would say it's not mismanagement so much as it's just a poorly structured program. It's essentially a formula grant program which imposes very few obligations on the recipient schools, and that's built into the structure

of it, and I don't think any better management is going to change that aspect of it.

You would have to make a very fundamental change in the law. And putting it in the hands of ONDCP would make it an utterly different program. But in the form that it is now, where it's essentially a formula grant, there is nothing here that suggests that this is an effective way of funding effective prevention programs. You can rewrite the law, but there's not a management issue.

Mr. KUCINICH. Let me ask you this. You conducted a RAND study in 2001 and concluded that the States' grants portion of the SDFSC program was profoundly flawed. Have you conducted any additional studies on the program since the passage of H.R. 1, which sought to legislatively correct some of the problems with the State grants portion of the SDFSC program? And your report, as you know, was cited in the 2010 budget as justification for eliminating the program. Is it applicable to the State grants portion of the SDFSC program as it's currently legislated?

Mr. REUTER. I have not followed this study further, so I cannot answer that question. If there have been made fundamental changes——

Mr. KUCINICH. That what?

Mr. REUTER. If fundamental changes have been made I simply don't know about them. So I can't answer your question.

Mr. KUCINICH. Well, we would like to hear from you about those fundamental changes, which of course would change your level of analysis. So just to say there's fundamental changes begs a lot more questions. The committee is going to send you a note that would give you a chance to elaborate on that.

I want to thank all of you for being here. Is anyone on the staff here from the Office of National Drug Policy? Good. I'm glad that you're here so you can take notes back and discuss some of the testimony.

And so I want to thank Director Kerlikowske and his staff for being present, as well as the other witnesses who are here. We want to continue to engage you and your expertise on these matters as we move to craft a sensible national drug policy.

This is the Domestic Policy Subcommittee. I'm Dennis Kucinich of Ohio, Chairman. We are the Committee on Oversight and Government Reform. Today's hearing has concerned the Office of National Drug Control Policy and the fiscal year 2010 National Drug Control Budget and the policy priorities of the national drug control policy under the new administration. Our committee will maintain—subcommittee will maintain an ongoing jurisdiction in this matter, and we appreciate all of you participating and we'll be talking again.

Thank you very much. This meeting stands adjourned.

[Whereupon, at 5 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

November 12, 2010

The Honorable Dennis J. Kucinich
Chairman
Committee on Oversight and Government Reform
Subcommittee on Domestic Policy
U.S. House of Representatives
B-349B Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

In response to your letter of May 7, 2010, I submitted my responses to the Subcommittee's Questions for the Record pertaining to the April 14th hearing entitled, *"ONDCP's Fiscal Year 2011 National Drug Control Budget: Are We Still Funding the War on Drugs?"*

However, in my response to Question #12, I noted ONDCP was working with the interagency to provide by-country estimates of international and interdiction funding, and would provide this data once available. We have been working with various Federal agencies to complete this request and have enclosed the final data for your review.

Thank you for your patience in getting this information to you. If you have any further questions, please do not hesitate to contact me directly at (202) 395-6700, or have your staff contact Christine Leonard, Director of ONDCP's Office of Legislative Affairs, at (202) 395-7225.

Sincerely,

R. Gil Kerlikowske
Director

Enclosure: Responses to Questions for the Record

cc: The Honorable Jim Jordan, Ranking Member

DOMESTIC POLICY SUBCOMMITTEE OF THE OVERSIGHT AND GOVERNMENT REFORM COMMITTEE

HEARING ON "ONDCP'S FISCAL YEAR 2011 NATIONAL DRUG CONTROL BUDGET: ARE WE STILL FUNDING THE WAR ON DRUGS?"

APRIL 14, 2010

QUESTIONS FOR THE RECORD FROM

CHAIRMAN DENNIS J. KUCINICH

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*ADDITIONAL DATA TO SUPPLEMENT QUESTION 12

Question 12: Please provide tabulated information showing source country and transit zone counternarcotics program spending (represented by the total international drug budget area) by agency and then, within each agency, by program activity (i.e. crop eradication, interdiction, aerial interdiction, marine programs, etc...) by year from 2000 to 2011(including the 2010 estimated and 2011 requested).

Answer: ONDCP tracks resources provided at the appropriation account, decision unit and drug control function-level detail (and not by the nation supported or the program activity). However, in order to provide the committee with a more responsive answer, ONDCP requested that the Departments identified as having international or interdiction funding in the *National Drug Control Strategy: FY 2011 Budget Summary* provide a breakout of their International and Interdiction funding by region/nation and by program activity for FY 2000 through FY 2011.

Attachment 1 summarizes the estimates provided to ONDCP by the Departments of State, Justice and Homeland Security (all applicable bureaus except Customs and Border Protection).

The Departments of Defense and Homeland Security (Customs and Border Protection) were unable to provide estimates broken down in such fashion. Defense was able to produce an estimate of support by country/region, but it does not breakout international vs. interdiction, or provide a breakout of the program activity. A summary of Defense's estimates is provided at Attachment 2.

National Drug Control Funding: Interdiction and International by Region/Nation (in Millions)

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Interdiction																
	Caribbean															
		Bahamas														
			State INL													
				Training	0.1	0.2										
				Other	0.3	0.4	0.6	0.6	0.7	0.7	0.4	0.5	0.5	0.4		
				Air/Maritime Operations	0.5	0.6	0.6	0.5	0.3	0.3	0.1	0.0	0.0	0.1		
				Total	**0.8**	**1.2**	**1.2**	**1.1**	**1.0**	**1.0**	**0.5**	**0.5**	**0.5**	**0.5**		
		Caribbean Basin														
			State INL													
				Intelligence												4.9
				Border Operations											1.0	
				Training											1.3	3.3
				Other											3.1	5.9
				Air/Maritime Operations											5.2	20.1
				Total											**10.6**	**34.2**
		Caribbean Region														
			DHS USCG													
				Air/Maritime and Border Operations	227.1	222.3	182.1	193.8	231.1	261.2	367.4	324.1	296.3	328.4	347.4	361.6
			State INL													
				Other									0.4	0.4		
				Total	**227.1**	**222.3**	**182.1**	**193.8**	**231.1**	**261.2**	**367.4**	**324.1**	**296.7**	**328.8**	**347.4**	**361.6**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Interdiction																
	Caribbean															
		Dominican Republic														
			State INL													
				Border Operations										0.2		
				Other									2.3	1.6	4.1	
				Training										0.9		
				Air/Maritime Operations										1.0		
				Total									**2.3**	**3.7**	**4.1**	
		Haiti														
			State INL													
				Border Ops										0.2		
				Training										0.2		
				Air/Maritime Operations							0.6	0.7	0.6	0.9	1.0	1.3
				Other							0.6	0.9	1.2	1.8	2.5	1.3
				Total							**1.2**	**1.5**	**1.8**	**3.1**	**3.5**	**2.6**
		Jamaica														
			State INL													
				Air/Maritime Operations			0.2	0.2	0.7	0.7	0.2	0.2	0.3	0.2		
				Border Operations	0.2		0.4	0.2	0.2	0.2	0.1					
				Other	0.2	0.3	0.4	0.4	0.3	0.4	0.6	0.4	0.7	0.5		
				Training	0.4		0.5	0.4	0.3	0.2	0.1	0.3				
				Total	**0.8**	**0.3**	**1.6**	**1.2**	**1.5**	**1.5**	**1.0**	**0.9**	**1.0**	**0.7**		
		Trinidad and Tobago														
			State INL													
				Training									0.2	0.2		
				Border Operations									0.1	0.1		
				Air/Maritime Operations									0.0	0.0		
				Other									0.2	0.2		
				Total									**0.4**	**0.4**		

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Interdiction																
	Central America															
		Central America Region														
			DHS USCG													
				Air/Maritime and Border Operations	378.5	370.4	303.4	323.1	385.1	435.3	612.3	540.1	493.8	547.4	578.9	602.7
			State INL													
				Other										1.1	0.3	2.1
				Air/Maritime Operations										1.9	14.7	23.1
				Intelligence										6.0	5.4	5.8
				Total	**378.5**	**370.4**	**303.4**	**323.1**	**385.1**	**435.3**	**612.3**	**540.1**	**493.8**	**556.4**	**599.3**	**633.6**
		El Salvador														
			State INL													
				Other									0.3			
				Training									0.5			
				Total									**0.7**			
		Guatemala														
			State INL													
				Other	0.7	1.2	1.4	1.1	1.0	1.7	1.2	1.3	1.6	2.5	1.1	
				Training	1.9	1.4	1.6	0.9	1.5	1.6	0.8	0.6	0.6			
				Total	**2.7**	**2.6**	**3.0**	**2.0**	**2.5**	**3.3**	**2.0**	**1.9**	**2.2**	**2.5**	**1.1**	
		Honduras														
			State INL													
				Training									0.6			
				Other									0.1			
				Total									**0.7**			

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Interdiction																
	Central America															
		Nicaragua														
			State INL													
				Air/Maritime Operations						0.5						
				Other						0.2			0.7			
				Training						0.4						
				Total						**1.0**			**0.7**			
		Panama														
			State INL													
				Intelligence								0.1				
				Border Operations			0.4	0.9	1.1	0.7	0.7	0.3	0.1	0.1		
				Air/Maritime Operations			1.7	1.4	1.5	1.3	1.0	0.7	0.2	0.5		
				Training	0.1		1.4	1.0	1.9	1.8	1.5	1.4	0.3	0.3		
				Other	4.9		1.6	1.2	2.1	2.3	1.2	1.6	0.4	1.3		
				Total	**5.0**		**5.0**	**4.5**	**6.5**	**6.0**	**4.5**	**4.0**	**1.0**	**2.2**		
	Latin America															
		Latin America Region														
			State INL													
				Other	7.5	7.8	9.3	5.8	4.3	2.9	2.3	1.7				
				Total	**7.5**	**7.8**	**9.3**	**5.8**	**4.3**	**2.9**	**2.3**	**1.7**				
	North America															
		Mexico														
			State INL													
				Other	2.1	2.0	3.1	3.8	2.5	2.3	10.8	6.4	46.0		1.0	
				Training	1.4	5.7	5.4	4.1	3.5	4.0	4.0	1.4	23.0	48.7	74.0	60.0
				Border Operations			0.5	0.5				6.7	77.0	116.0	13.5	8.0
				Air/Maritime Operations	0.2	1.2	2.1	3.6	10.0	10.3	5.0			214.5		
				Intelligence	0.3	1.2	1.0		1.0	1.0		1.0	5.6	17.0	11.0	10.0
				Total	**4.1**	**10.0**	**12.0**	**12.0**	**17.0**	**17.5**	**19.8**	**15.5**	**151.5**	**396.2**	**99.5**	**78.0**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Interdiction																
	South America															
		South America														
			DHS USCG													
				Air/Maritime and Border Operations	151.4	148.2	121.4	129.2	154.4	174.1	244.9	216.0	197.5	219.0	231.6	241.1
				Total	**151.4**	**148.2**	**121.4**	**129.2**	**154.4**	**174.1**	**244.9**	**216.0**	**197.5**	**219.0**	**231.6**	**241.1**
	Worldwide															
			DHS CNE													
										0.8	1.3	2.0	2.1	3.0	2.9	3.1
				Total						**0.8**	**1.3**	**2.0**	**2.1**	**3.0**	**2.9**	**3.1**
International																
	Africa															
		Africa Region														
			State INL													
				Law Enforcement								0.1				
				Total								**0.1**				
		Benin														
			State INL													
				Other												40.0
				Law Enforcement												335.0
				Total												**375.0**
		Cape Verde														
			State INL													
				Other									0.0	0.0	0.1	0.1
				Law Enforcement									0.5	0.5	0.6	1.0
				Total									**0.5**	**0.5**	**0.6**	**1.0**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Africa															
		Egypt														
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Law Enforcement	1.6	1.3	1.1	1.1	0.9	1.7	1.3	1.5	1.3	1.6	1.6	1.7
				Total	**1.7**	**1.3**	**1.2**	**1.2**	**0.9**	**1.7**	**1.4**	**1.6**	**1.4**	**1.6**	**1.7**	**1.8**
		Ghana														
			DOJ DEA													
				Intelligence									0.0	0.1	0.1	0.1
				Law Enforcement									0.5	1.3	1.9	2.1
			State INL													
				Law Enforcement									0.2	0.5	0.5	1.6
				Other									0.0		0.1	0.1
				Total									**0.8**	**1.8**	**2.5**	**3.9**
		Guinea														
			State INL													
				Other												0.0
				Law Enforcement										0.1		0.5
				Total										**0.1**		**0.5**
		Guinea-Bissau														
			State INL													
				Other												0.2
				Law Enforcement											1.5	2.9
				Total											**1.5**	**3.0**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Africa															
		Morocco														
			DHS ICE													
				Law Enforcement									1.7	0.0	0.0	0.0
			State INL													
				Training/Equipping											0.1	0.8
				Total									**1.7**	**0.0**	**0.1**	**0.8**
		Nigeria														
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1
				Law Enforcement	1.9	2.4	1.9	1.9	1.8	1.6	2.0	3.3	2.0	2.7	2.3	2.4
			State INL													
				Other			0.4	0.4			0.2	0.4		0.3	0.5	0.7
				Law Enforcement			0.5	0.2	0.6	0.6	0.1		0.6	0.1		1.8
				Total	**2.0**	**2.5**	**2.9**	**2.6**	**2.5**	**2.2**	**2.4**	**3.9**	**2.7**	**3.2**	**2.9**	**5.0**
		Senegal														
			INL													
				Other												0.5
			State INL													
				Law Enforcement												1.0
				Total												**1.5**
		Sierra Leone														
			State INL													
				Other											0.0	0.1
				Law Enforcement											0.2	1.1
				Total											**0.3**	**1.2**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Africa															
		South Africa														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Law Enforcement	1.5	1.1	1.1	0.9	1.0	1.4	1.7	1.6	1.9	2.1	2.1	2.3
				Total	**1.6**	**1.1**	**1.1**	**1.0**	**1.0**	**1.4**	**1.8**	**1.7**	**2.1**	**2.2**	**2.2**	**2.4**
		The Gambia														
			State INL													
				Other												0.0
				Law Enforcement												0.5
				Total												**0.5**
		Togo														
			State INL													
				Other												0.0
				Law Enforcement												0.4
				Total												**0.4**
	Caribbean															
		Bahamas														
			DOJ DEA													
				Intelligence	0.6	0.4	0.4	0.5	0.4	0.5	0.5	0.7	0.9	0.6	0.7	0.8
				Law Enforcement	12.3	8.5	8.0	9.7	8.8	10.8	11.6	14.3	12.6	12.7	15.5	16.5
				Total	**12.9**	**8.9**	**8.4**	**10.2**	**9.2**	**11.3**	**12.1**	**14.9**	**13.5**	**13.3**	**16.2**	**17.3**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Caribbean															
		Barbados														
			DOJ DEA													
				Law Enforcement	2.5	2.7	2.9	3.2	2.7	3.6	2.7	3.6	3.5	3.6	3.8	4.0
				Intelligence	0.1	0.1	0.1	0.2	0.1	0.2	0.1	0.2	0.3	0.2	0.2	0.2
				Total	**2.6**	**2.8**	**3.0**	**3.4**	**2.8**	**3.8**	**2.8**	**3.8**	**3.8**	**3.8**	**4.0**	**4.2**
		Caribbean Region														
			DHS ICE													
				Law Enforcement									0.2	0.2	0.2	0.2
				Total									**0.2**	**0.2**	**0.2**	**0.2**
		Dominican Republic														
			DHS ICE													
				Law Enforcement									0.1	0.2	0.2	0.2
			DOJ DEA													
				Intelligence	0.3	0.3	0.2	0.2	0.2	0.3	0.3	0.4	0.5	0.3	0.3	0.3
				Law Enforcement	6.0	6.9	5.2	4.3	4.5	5.3	6.0	7.7	6.8	6.3	6.8	7.2
				Total	**6.3**	**7.3**	**5.4**	**4.5**	**4.7**	**5.6**	**6.3**	**8.1**	**7.4**	**6.8**	**7.3**	**7.8**
		Haiti														
			DOJ DEA													
				Intelligence	0.2	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.2	0.1	0.2	0.2
				Law Enforcement	4.6	2.6	2.7	3.2	2.8	2.7	2.8	3.2	3.3	2.8	3.2	3.4
				Total	**4.9**	**2.7**	**2.8**	**3.3**	**3.0**	**2.9**	**2.9**	**3.4**	**3.5**	**2.9**	**3.4**	**3.6**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Caribbean															
		Jamaica														
			DHS ICE													
				Law Enforcement									0.2	0.1	0.1	0.1
			DOJ DEA													
				Intelligence	0.2	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.2	0.2	0.2
				Law Enforcement	3.2	2.6	2.6	3.0	3.2	4.0	3.7	4.2	3.9	4.1	4.3	4.5
				Total	**3.4**	**2.8**	**2.8**	**3.2**	**3.3**	**4.2**	**3.9**	**4.4**	**4.4**	**4.4**	**4.5**	**4.8**
		Netherlands Antilles														
			DOJ DEA													
				Law Enforcement	1.4	1.4	1.6	2.1	2.3	2.3	2.3	2.7	2.3	2.8	3.0	3.2
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.2
				Total	**1.5**	**1.5**	**1.6**	**2.2**	**2.4**	**2.4**	**2.4**	**2.8**	**2.5**	**2.9**	**3.2**	**3.4**
		Trinidad and Tobago														
			DOJ DEA													
				Law Enforcement	2.0	1.3	1.9	1.8	2.0	2.4	2.4	2.9	2.2	2.8	5.3	5.6
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.2	0.3
				Total	**2.1**	**1.4**	**2.0**	**1.8**	**2.1**	**2.5**	**2.5**	**3.1**	**2.4**	**3.0**	**5.5**	**5.9**
	Central America															
		Belize														
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2
				Law Enforcement	1.1	1.5	1.9	1.7	1.9	1.8	3.0	2.2	2.9	3.5	3.2	3.4
				Total	**1.1**	**1.6**	**2.0**	**1.8**	**1.9**	**1.9**	**3.2**	**2.3**	**3.1**	**3.6**	**3.4**	**3.6**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Central America															
		Costa Rica														
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
				Law Enforcement	3.2	2.4	2.8	3.3	2.9	2.6	2.6	3.3	3.2	3.9	4.0	4.3
				Total	**3.3**	**2.5**	**2.9**	**3.4**	**3.0**	**2.7**	**2.7**	**3.5**	**3.4**	**4.1**	**4.2**	**4.5**
		El Salvador														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1
				Law Enforcement	1.3	1.8	1.6	1.7	1.6	1.7	1.9	2.4	2.2	2.9	2.6	2.8
				Total	**1.4**	**1.9**	**1.7**	**1.8**	**1.6**	**1.8**	**2.0**	**2.5**	**2.4**	**3.1**	**2.8**	**3.0**
		Guatemala														
			DHS ICE													
				Law Enforcement									0.0	0.1	0.1	0.1
			DOJ DEA													
				Law Enforcement	3.8	2.7	2.4	2.6	2.4	3.3	3.5	4.4	3.5	3.6	4.2	4.4
				Intelligence	0.2	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.2	0.2	0.2
				Total	**4.0**	**2.9**	**2.5**	**2.7**	**2.6**	**3.5**	**3.7**	**4.6**	**3.8**	**3.8**	**4.4**	**4.7**
		Honduras														
			DHS ICE													
				Law Enforcement									0.2	0.1	0.1	0.1
			DOJ DEA													
				Law Enforcement	2.0	1.3	1.2	1.4	1.0	1.3	1.4	1.6	1.9	2.0	2.6	2.7
				Intelligence	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Total	**2.1**	**1.3**	**1.2**	**1.5**	**1.1**	**1.3**	**1.5**	**1.7**	**2.3**	**2.2**	**2.8**	**2.9**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Central America															
		Nicaragua														
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.2
				Law Enforcement	1.9	1.8	1.5	1.6	1.4	1.3	2.0	2.5	2.8	2.7	3.0	3.2
				Total	**2.0**	**1.8**	**1.6**	**1.7**	**1.5**	**1.4**	**2.1**	**2.6**	**3.0**	**2.8**	**3.1**	**3.3**
		Panama														
			DHS ICE													
				Law Enforcement									0.1	0.2	0.2	0.2
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.2	0.1	0.1	0.2	0.2	0.3	0.2	0.3	0.3
				Law Enforcement	3.1	2.3	2.7	3.3	2.8	3.0	3.6	4.5	4.2	4.7	5.5	5.9
			State USAID													
				Alternative Development							0.4		0.0	0.0	0.0	0.0
				Total	**3.3**	**2.4**	**2.8**	**3.5**	**2.9**	**3.2**	**4.2**	**4.7**	**4.6**	**5.2**	**6.0**	**6.4**
	Europe															
		Austria														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Law Enforcement	2.0	1.8	1.8	2.2	2.1	1.9	1.9	2.0	1.9	2.2	2.0	2.1
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Total	**2.1**	**1.8**	**1.9**	**2.3**	**2.2**	**2.0**	**2.0**	**2.1**	**2.0**	**2.3**	**2.1**	**2.2**
		Belgium														
			DOJ DEA													
				Law Enforcement	1.4	1.0	0.9	0.8	0.6	1.2	3.3	3.2	3.1	3.6	3.7	4.0
				Intelligence	0.1	0.0	0.0	0.0	0.0	0.1	0.2	0.2	0.2	0.2	0.2	0.2
				Total	**1.4**	**1.1**	**0.9**	**0.8**	**0.7**	**1.3**	**3.5**	**3.3**	**3.4**	**3.7**	**3.9**	**4.2**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Europe															
		Cyprus														
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Law Enforcement	1.4	1.6	1.3	1.3	1.5	1.6	1.6	1.4	1.9	2.1	2.8	3.0
				Total	**1.5**	**1.6**	**1.4**	**1.4**	**1.6**	**1.7**	**1.7**	**1.4**	**2.1**	**2.2**	**3.0**	**3.2**
		Denmark														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Intelligence	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1
				Law Enforcement	1.5	0.9	1.0	1.0	1.0	1.0	1.1	2.1	1.6	1.6	2.0	2.1
				Total	**1.5**	**1.0**	**1.1**	**1.0**	**1.0**	**1.0**	**1.1**	**2.2**	**1.7**	**1.7**	**2.2**	**2.3**
		France														
			DHS ICE													
				Law Enforcement									0.0	0.1	0.1	0.1
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.2	0.2
				Law Enforcement	2.3	1.9	2.0	2.1	1.9	1.8	2.1	2.5	2.7	2.7	4.0	4.3
				Total	**2.4**	**2.0**	**2.0**	**2.2**	**2.0**	**1.9**	**2.2**	**2.6**	**2.9**	**2.9**	**4.3**	**4.5**
		Germany														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Law Enforcement	3.1	2.3	2.1	2.0	2.1	2.0	1.9	1.2	1.5	1.9	1.8	1.9
				Total	**3.2**	**2.4**	**2.2**	**2.1**	**2.2**	**2.1**	**2.0**	**1.3**	**1.6**	**2.0**	**1.9**	**2.0**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Europe															
		Greece														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.2	0.2
				Law Enforcement	2.1	2.0	1.9	2.2	2.2	2.9	3.1	3.1	2.7	3.1	3.9	4.1
				Total	**2.2**	**2.0**	**1.9**	**2.4**	**2.3**	**3.0**	**3.3**	**3.2**	**2.9**	**3.3**	**4.1**	**4.3**
		Italy														
			DHS ICE													
				Law Enforcement									0.0	0.2	0.2	0.2
			DOJ DEA													
				Intelligence	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.5	0.3	0.3	0.3
				Law Enforcement	3.6	3.7	3.9	4.5	4.6	4.5	5.8	7.0	7.3	7.1	6.5	6.9
				Total	**3.7**	**3.9**	**4.1**	**4.7**	**4.8**	**4.7**	**6.1**	**7.3**	**7.9**	**7.6**	**7.0**	**7.5**
		Netherlands														
			DHS ICE													
				Law Enforcement									0.0	0.1	0.1	0.1
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1
				Law Enforcement	2.2	1.2	1.4	1.4	1.5	2.1	2.5	2.7	2.9	2.5	2.6	2.7
				Total	**2.3**	**1.2**	**1.5**	**1.5**	**1.6**	**2.2**	**2.6**	**2.8**	**3.1**	**2.6**	**2.8**	**2.9**
		Poland														
			DOJ DEA													
				Law Enforcement	0.0	0.0	0.0	0.0	0.0	0.0	0.6	1.3	1.1	1.2	1.1	1.1
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1
				Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.6**	**1.3**	**1.2**	**1.2**	**1.1**	**1.2**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Europe															
		Romania														
			DOJ DEA													
				Law Enforcement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.8	0.9	0.9
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
				Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.5**	**0.9**	**0.9**	**1.0**
		Russia														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Law Enforcement	1.5	1.5	1.6	1.8	1.6	1.4	1.7	2.8	2.7	3.1	2.8	3.0
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1
				Total	**1.6**	**1.5**	**1.7**	**1.9**	**1.7**	**1.4**	**1.8**	**2.9**	**2.9**	**3.3**	**3.0**	**3.2**
		Spain														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Law Enforcement	1.7	1.6	1.6	2.1	4.5	2.0	2.3	3.3	3.6	4.5	4.0	4.3
				Intelligence	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.2	0.3	0.2	0.2	0.2
				Total	**1.8**	**1.7**	**1.7**	**2.2**	**4.7**	**2.1**	**2.4**	**3.5**	**3.9**	**4.8**	**4.2**	**4.5**
		Switzerland														
			DHS ICE													
				Law Enforcement									0.1	0.0	0.0	0.0
			DOJ DEA													
				Law Enforcement	2.1	1.5	1.3	2.1	1.7	1.1	1.1	1.8	1.6	1.4	1.9	2.1
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Total	**2.2**	**1.6**	**1.4**	**2.2**	**1.7**	**1.1**	**1.1**	**1.9**	**1.8**	**1.5**	**2.0**	**2.2**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Europe															
		United Kingdom														
			DHS ICE													
				Law Enforcement									0.0	0.1	0.1	0.1
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.2
				Law Enforcement	1.3	1.1	1.1	1.4	1.2	1.2	2.0	3.1	2.8	2.6	3.2	3.4
				Total	**1.3**	**1.2**	**1.1**	**1.5**	**1.2**	**1.3**	**2.0**	**3.2**	**3.1**	**2.8**	**3.4**	**3.6**
	North America															
		Canada														
			DHS ICE													
				Law Enforcement									0.2	0.2	0.2	0.2
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.2	0.2	0.2
				Law Enforcement	2.3	1.5	1.1	1.7	2.1	2.7	3.1	4.0	3.8	3.7	4.1	4.3
				Total	**2.4**	**1.6**	**1.2**	**1.8**	**2.2**	**2.8**	**3.2**	**4.2**	**4.3**	**4.1**	**4.4**	**4.7**
		Mexico														
			DHS ICE													
				Law Enforcement									0.1	1.3	1.2	1.3
			DOJ DEA													
				Law Enforcement	30.4	23.2	26.7	28.1	26.2	28.4	33.9	35.8	41.1	43.5	39.9	42.5
				Intelligence	1.4	1.1	1.3	1.3	1.2	1.3	1.6	1.7	3.0	2.1	1.9	2.0
				Total	**31.9**	**24.3**	**28.0**	**29.4**	**27.4**	**29.8**	**35.5**	**37.4**	**44.1**	**46.9**	**43.1**	**45.8**
	SE Asia															
		Australia														
			DOJ DEA													
				Law Enforcement	0.6	0.4	0.5	0.6	0.6	1.1	1.0	1.3	1.3	1.6	1.8	2.0
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.1	0.1
				Total	**0.6**	**0.5**	**0.5**	**0.6**	**0.6**	**1.1**	**1.1**	**1.4**	**1.4**	**1.6**	**1.9**	**2.0**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	SE Asia															
		Burma														
			DOJ DEA													
				Law Enforcement	2.1	1.6	1.5	1.7	1.2	1.7	1.8	1.8	1.7	2.1	2.3	2.5
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Total	**2.2**	**1.7**	**1.5**	**1.8**	**1.3**	**1.7**	**1.9**	**1.9**	**1.8**	**2.2**	**2.4**	**2.6**
		China														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Intelligence	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1
				Law Enforcement	1.2	1.1	1.0	1.6	1.2	2.3	2.4	2.6	2.7	2.3	2.4	2.5
				Total	**1.2**	**1.2**	**1.0**	**1.7**	**1.3**	**2.4**	**2.5**	**2.7**	**2.9**	**2.4**	**2.5**	**2.6**
		Hong Kong														
			DHS ICE													
				Law Enforcement									0.1	0.1	0.1	0.1
			DOJ DEA													
				Intelligence	0.1	0.2	0.2	0.1	0.1	0.1	0.2	0.2	0.3	0.2	0.2	0.2
				Law Enforcement	2.9	4.1	3.3	2.8	3.0	3.1	3.6	4.0	3.5	3.4	3.8	4.0
				Total	**3.0**	**4.3**	**3.5**	**3.0**	**3.2**	**3.2**	**3.8**	**4.2**	**3.8**	**3.6**	**4.1**	**4.3**
		India														
			DHS ICE													
				Law Enforcement									0.0	0.1	0.1	0.1
			DOJ DEA													
				Law Enforcement	1.7	1.9	1.7	1.6	1.8	1.7	1.8	2.4	2.1	2.0	2.8	3.0
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1
				Total	**1.8**	**2.0**	**1.8**	**1.7**	**1.9**	**1.7**	**1.9**	**2.5**	**2.3**	**2.2**	**3.0**	**3.2**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	SE Asia															
		Indonesia														
			State INL													
				Other							15.0		50.0			25.0
				Law Enforcement							0.5	0.5	0.5	0.5	0.5	0.5
				Total							**15.5**	**0.5**	**50.5**	**0.5**	**0.5**	**25.5**
		Japan														
			DHS ICE													
				Law Enforcement									0.0	0.2	0.2	0.2
			DOJ DEA													
				Law Enforcement	0.7	1.0	0.8	1.0	1.0	1.5	1.7	2.1	1.8	1.8	2.9	3.1
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Total	**0.7**	**1.1**	**0.8**	**1.1**	**1.0**	**1.6**	**1.8**	**2.2**	**1.9**	**2.1**	**3.2**	**3.4**
		Laos														
			DOJ DEA													
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0
				Law Enforcement	0.7	0.5	0.6	0.6	0.7	0.9	0.9	1.1	0.8	0.7	0.5	0.6
			State INL													
				Other	0.4	0.4	0.6	0.6	0.4		0.5	0.5	0.7	0.5	0.6	0.6
				Alternative Development	3.3	3.3	2.3	1.5	1.3		0.4	0.2	0.5	0.1		
				Law Enforcement	0.3	0.5	0.2	0.1	0.1	0.1	0.1		0.3	0.3	0.3	0.8
				Demand Reduction			0.9	0.3	0.2		0.0	0.1	0.1	0.1	0.2	0.2
				Total	**4.8**	**4.8**	**4.6**	**3.1**	**2.7**	**1.0**	**1.9**	**1.9**	**2.4**	**1.7**	**1.6**	**2.1**
		Malaysia														
			DOJ DEA													
				Law Enforcement	1.6	1.0	1.2	1.1	1.1	0.9	1.0	1.4	1.5	1.3	1.6	1.7
				Intelligence	0.1	0.0	0.1	0.1	0.1	0.0	0.0	0.1	0.1	0.1	0.1	0.1
				Total	**1.7**	**1.1**	**1.2**	**1.2**	**1.1**	**1.0**	**1.0**	**1.5**	**1.6**	**1.4**	**1.7**	**1.8**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	SE Asia															
		Philippines														
			State INL													
				Other							0.2					
				Law Enforcement						0.1	0.2	0.1				
				Total						**0.1**	**0.3**	**0.1**				
		Phillippines														
			DHS ICE													
				Law Enforcement									0.1	0.0	0.0	0.0
			DOJ DEA													
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Law Enforcement	0.7	0.8	1.0	1.0	0.9	1.1	1.2	1.2	1.2	1.3	1.3	1.4
				Total	**0.7**	**0.9**	**1.1**	**1.1**	**0.9**	**1.2**	**1.3**	**1.3**	**1.4**	**1.3**	**1.4**	**1.5**
		Singapore														
			DHS ICE													
				Law Enforcement									0.0	0.1	0.1	0.1
			DOJ DEA													
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.1
				Law Enforcement	2.2	1.5	1.5	1.9	1.7	1.8	2.2	2.8	3.2	3.3	2.4	2.5
				Total	**2.3**	**1.5**	**1.5**	**2.0**	**1.7**	**1.8**	**2.3**	**2.9**	**3.5**	**3.5**	**2.6**	**2.7**
		South Korea														
			DHS ICE													
				Law Enforcement									0.0	0.1	0.0	0.1
			DOJ DEA													
				Intelligence	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1
				Law Enforcement	0.6	0.8	0.6	0.6	1.3	1.0	1.1	2.0	1.4	1.3	1.5	1.6
				Total	**0.6**	**0.9**	**0.7**	**0.6**	**1.4**	**1.1**	**1.2**	**2.1**	**1.5**	**1.5**	**1.6**	**1.8**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	SE Asia															
		Thailand														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Law Enforcement	18.1	18.4	15.6	15.6	14.1	16.0	16.2	20.6	20.3	22.6	25.1	26.7
				Intelligence	0.9	0.9	0.7	0.7	0.7	0.8	0.8	1.0	1.5	1.1	1.2	1.3
			State INL													
				Alternative Development	0.7	0.7	0.8	0.7	0.4	0.1						
				Other	0.8	0.8	0.8	0.8	0.6	0.8	0.9	0.6				
				Law Enforcement	1.2	1.2	1.3	1.8	0.7	0.3	0.1	0.1				
				Demand Reduction	0.3	0.3	0.6	0.4	0.2	0.1						
				Total	**21.9**	**22.2**	**19.8**	**20.1**	**16.6**	**18.0**	**18.0**	**22.3**	**21.8**	**23.7**	**26.3**	**27.9**
		Vietnam														
			DOJ DEA													
				Intelligence	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
				Law Enforcement	0.8	1.2	1.1	1.2	1.1	1.1	1.3	1.9	1.4	1.6	1.7	1.8
			State INL													
				Law Enforcement												0.2
				Other												0.0
				Total	**0.8**	**1.3**	**1.2**	**1.2**	**1.2**	**1.1**	**1.4**	**2.0**	**1.5**	**1.7**	**1.8**	**2.1**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	South America													-		
		Argentina														
			DHS ICE													
				Law Enforcement									0.0	0.1	0.1	0.1
			DOJ DEA													
				Intelligence	0.1	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3
				Law Enforcement	2.7	3.5	3.9	3.7	3.0	3.2	3.4	4.2	4.3	6.0	5.5	5.9
			State INL													
				Law Enforcement									0.1	0.1	0.2	0.2
				Demand Reduction												0.1
				Other									0.0	0.0	0.0	0.0
				Total	**2.8**	**3.7**	**4.1**	**3.9**	**3.1**	**3.4**	**3.5**	**4.4**	**4.7**	**6.4**	**6.1**	**6.5**
		Bolivia														
			DOJ DEA													
				Intelligence	1.5	1.3	1.1	1.1	1.0	1.0	1.0	1.2	2.0	0.5	0.0	0.0
				Law Enforcement	32.6	27.6	23.7	22.5	21.0	21.4	21.7	26.3	27.2	10.0	0.0	0.0
			State INL													
				Alternative Development	99.0	18.0	35.6	38.2	38.4	41.7	33.7	28.0				
				Law Enforcement	30.9	14.5	23.3	22.1	22.1	26.4	22.1	18.7	16.3	11.3	7.5	7.5
				Training Equipping	16.8	9.1	15.5	14.4	14.3	6.5	8.7	6.3	2.2	2.0	1.4	1.4
				Eradication	7.8	6.9	9.3	12.0	12.0	11.4	10.2	8.5	7.3	8.5	6.9	6.9
				Other	2.7	2.7	2.8	3.2	3.5	3.3	3.8	3.8	3.8	3.8	4.2	4.2
				Demand Reduction	0.9	0.8	1.0	0.8	0.8	1.0	0.8	0.6	0.5	0.3		
			State USAID													
				Alternative Development	80.0		39.6	41.7	41.7	39.7	34.6	28.0	18.6	15.0	18.9	15.7
				Total	**272.2**	**80.9**	**152.0**	**156.0**	**154.7**	**152.4**	**136.6**	**121.6**	**77.9**	**51.4**	**39.0**	**35.7**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	South America															
		Brazil														
			DHS ICE													
				Law Enforcement									0.3	0.0	0.0	0.0
			DOJ DEA													
				Law Enforcement	6.2	7.2	7.3	7.6	5.5	5.4	6.6	8.9	10.1	14.6	15.8	16.8
				Intelligence	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.4	0.7	0.7	0.7	0.8
			State INL													
				Other	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.7	0.7	0.7	0.8	0.8
				Law Enforcement	4.4	1.4	5.1	5.1	9.3	8.0	4.9	2.7	0.3	0.3	0.2	0.2
				Demand Reduction	0.2	0.2	0.5	0.5	0.5	0.5	0.5	0.6				
				Total	**11.5**	**9.5**	**13.6**	**13.9**	**16.0**	**14.5**	**12.8**	**13.3**	**12.2**	**16.3**	**17.5**	**18.6**
		Chile														
			DOJ DEA													
				Law Enforcement	2.0	1.9	2.1	1.7	1.4	2.0	2.4	2.3	2.5	2.6	2.7	2.9
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1
			State INL													
				Law Enforcement									0.1			
				Other									0.0			
				Total	**2.1**	**2.0**	**2.2**	**1.8**	**1.5**	**2.1**	**2.5**	**2.4**	**2.7**	**2.7**	**2.8**	**3.0**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	South America															
		Colombia														
			DHS ICE													
				Law Enforcement									1.0	1.2	1.2	1.2
			DOJ DEA													
				Intelligence	1.1	1.6	1.2	1.5	1.6	1.4	1.8	2.4	4.3	3.1	3.2	3.4
				Law Enforcement	23.3	33.2	26.3	30.8	34.3	29.8	38.3	51.3	58.9	66.0	67.9	72.2
			State INL													
				Eradication	4.0		37.4	63.7	44.2	82.5	81.7	82.0	64.0	55.0	53.0	55.0
				Demand Reduction	2.1	0.6	0.5	0.5	0.3	0.2	0.2	0.5		0.5	0.5	0.5
				Other	3.5	0.5	7.8	7.0	7.8	6.9	7.8	7.4	8.5	10.0	6.7	7.7
				Intelligence	9.0			20.0								
				Alternative Development	208.0	0.5	107.9	122.2	121.5	124.7	129.9	139.9				
				Training Equipping	250.3	0.3	28.0	42.0	22.6	27.2	26.9	7.0	39.0	44.5	62.7	33.7
				Law Enforcement	417.6	46.2	198.4	324.8	277.6	221.3	218.3	228.2	133.2	122.1	77.3	90.2
			State USAID													
				Alternative Development	119.5		101.9	122.2	121.5	121.8	127.7	61.1	114.2	113.2	109.4	120.2
				Total	**####**	**82.8**	**509.3**	**734.7**	**631.3**	**615.7**	**632.6**	**579.8**	**422.9**	**415.7**	**381.8**	**384.1**
		Ecuador														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Intelligence	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.5	0.7	0.8	0.6	0.6
				Law Enforcement	5.1	5.7	5.7	6.1	5.3	6.4	7.8	10.0	9.2	17.7	11.7	12.5
			State INL													
				Other	0.5	0.5	0.6	0.7	0.7	0.7	0.8	0.8	0.8	1.3	1.2	1.2
				Demand Reduction		0.0	0.1	0.1	0.2	0.1	0.1	0.1	0.0	0.1	0.1	0.0
				Alternative Development	8.0		10.5	15.9	15.2	14.9	11.4	8.4				
				Law Enforcement	12.7	1.7	13.8	14.2	18.9	10.1	7.5	8.0	6.1	6.2	3.3	6.3
			State USAID													
				Alternative Development	8.0		10.0	15.9	14.9	14.6	10.6	9.0	2.5	8.2	10.3	10.0
				Total	**34.5**	**8.2**	**41.0**	**53.2**	**55.5**	**47.1**	**38.6**	**36.8**	**19.4**	**34.2**	**27.0**	**30.6**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	South America															
		Paraguay														
			DOJ DEA													
				Law Enforcement	2.1	1.7	1.9	2.0	1.9	1.7	2.0	2.6	3.0	4.9	6.7	7.1
				Intelligence	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3
			State INL													
				Law Enforcement									0.2	0.2	0.4	0.3
				Demand Reduction											0.0	0.0
				Other									0.1	0.1	0.1	0.7
				Total	**2.2**	**1.8**	**2.0**	**2.0**	**2.0**	**1.8**	**2.1**	**2.7**	**3.5**	**5.4**	**7.5**	**8.4**
		Peru														
			DOJ DEA													
				Intelligence	0.8	0.8	0.8	0.9	0.8	0.8	0.8	0.8	1.6	1.4	1.4	1.4
				Law Enforcement	16.0	16.5	16.4	18.7	16.5	16.1	17.4	16.5	21.4	29.1	28.8	30.7
			State INL													
				Demand Reduction	1.0	1.0	1.3	0.8	1.0	2.2	2.2	1.9	1.0	1.1	0.8	0.6
				Alternative Development	27.3	27.0	67.5	68.6	49.7	53.9	48.5	47.2				
				Other	34.7	2.7	3.0	3.0	3.2	3.6	4.0	4.0	3.8	3.8	4.0	4.0
				Training Equipping	9.1	2.7	9.9	8.7	10.4	9.8	8.5	4.5	2.7	2.9	4.0	4.2
				Eradication	4.7	4.7	22.2	13.4	12.8	15.6	14.1	32.5	20.5	31.3	18.0	17.4
				Law Enforcement	35.2	10.0	38.7	33.6	38.9	30.3	29.6	13.2	8.6	8.6	13.2	10.9
			State USAID													
				Alternative Development		25.8	62.5	68.6	49.7	51.2	46.6	47.2	23.8	31.5	29.5	38.0
				Total	**128.8**	**91.0**	**222.2**	**216.2**	**182.9**	**183.4**	**171.8**	**167.6**	**83.3**	**109.6**	**99.7**	**107.1**
		South America Regional														
			State USAID													
				Alternative Development			5.0						0.0	0.0	0.0	0.0
				Total			**5.0**						**0.0**	**0.0**	**0.0**	**0.0**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	South America															
		Suriname														
			DOJ DEA													
				Law Enforcement	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.9	2.2	2.1	2.0	2.1
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.1	0.1	0.1
				Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.1**	**2.0**	**2.3**	**2.2**	**2.0**	**2.2**
		Venezuela														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			State INL													
				Intelligence			0.1	0.0								
				Demand Reduction	0.0	0.1	0.5	0.1	0.1	0.0	0.2					
				Law Enforcement	3.8	0.7	2.7	0.8	1.9	1.5	0.9	0.2		0.5		
				Other	0.4	0.5	1.8	1.1	3.0	1.5	1.1	0.8				
				Total	**4.2**	**1.2**	**5.0**	**2.1**	**5.0**	**3.0**	**2.2**	**1.0**	**0.0**	**0.5**	**0.0**	**0.0**
		Venzuela														
			DOJ DEA													
				Law Enforcement	4.6	4.8	5.5	4.9	4.7	4.9	5.6	6.8	3.5	2.5	2.1	2.2
				Intelligence	0.2	0.2	0.3	0.2	0.2	0.2	0.3	0.3	0.3	0.1	0.1	0.1
				Total	**4.8**	**5.0**	**5.7**	**5.1**	**4.9**	**5.1**	**5.9**	**7.2**	**3.7**	**2.6**	**2.2**	**2.3**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	SW Asia															
		Afghanistan														
			DOJ DEA													
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.1	0.2	0.4	0.5	0.8	0.8	0.8
				Law Enforcement	0.0	0.0	0.0	0.2	0.0	1.1	3.8	7.4	6.7	16.3	16.2	17.2
			State INL													
				Other						95.0	114.5	111.7	123.7	172.1	144.0	143.0
				Demand Reduction			2.0			5.0	4.7	8.0	4.0	15.0	10.0	14.0
				Law Enforcement					3.5	64.5	5.0	12.0	17.2	21.0	58.6	48.6
				Eradication					40.0	93.3	18.5	45.0	46.8	14.0	5.0	5.0
				Alternative Development			17.5		5.0		3.0	20.0	19.9	70.0	40.0	40.0
			State USAID													
				Alternative Development			3.0	1.0	5.0	18.5	120.9	228.9	177.1	164.6	344.9	185.0
				Total	**0.0**	**0.0**	**22.5**	**1.2**	**53.5**	**277.5**	**270.5**	**433.5**	**395.9**	**473.8**	**619.4**	**453.6**
		Asia/Middle East Regional														
			State INL													
				Law Enforcement		1.5	3.2	1.6	0.3							
				Alternative Development		0.3	1.3	0.3	0.2	0.2						
				Other		0.5		0.6	0.5	0.3						
				Total		**2.2**	**4.4**	**2.4**	**1.0**	**0.5**						
		Iraq														
			State INL													
				Demand Reduction											1.0	2.5
				Total											**1.0**	**2.5**
		Kazakhstan														
			DOJ DEA													
				Law Enforcement											1.2	1.3
				Intelligence											0.1	0.1
				Total											**1.2**	**1.3**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	SW Asia															
		Kyrgyzstan														
			DOJ DEA													
				Law Enforcement										0.0		0.0
				Intelligence										0.0		0.0
				Total										**0.0**		**0.0**
		Lebanon														
			State INL													
				Training/Equipping											2.0	
				Total											**2.0**	
		Pakistan														
			DOJ DEA													
				Law Enforcement	6.0	7.5	6.8	4.5	4.4	4.3	6.4	7.6	7.1	4.4	1.1	1.2
				Intelligence	0.3	0.4	0.3	0.2	0.2	0.2	0.3	0.4	0.5	0.2	0.1	0.1
			State INL													
				Other	1.7	1.7	5.1	5.7		1.7	6.0	2.3	1.0	1.3	2.0	3.9
				Training Equipping			0.3	1.5	1.5	1.0	1.0		1.0	1.3	1.5	2.0
				Demand Reduction	0.1	0.1						0.5	0.5	0.5	1.5	1.0
				Law Enforcement	0.8	0.9						1.7		0.8	2.0	3.0
				Total	**8.8**	**10.5**	**12.5**	**11.9**	**6.1**	**7.2**	**13.7**	**12.5**	**10.1**	**8.5**	**8.2**	**11.1**
		Tajikistan														
			DOJ DEA													
				Law Enforcement	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.4	1.2	1.8	2.1	2.2
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1
				Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.4**	**0.5**	**1.3**	**1.9**	**2.2**	**2.3**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	SW Asia															
		Turkey														
			DOJ DEA													
				Intelligence	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.5	0.9	0.5	0.5	0.5
				Law Enforcement	5.2	4.0	4.5	4.4	5.1	4.4	6.5	10.1	12.1	10.4	9.8	10.5
			State INL													
				Other									0.0	0.0		0.0
				Demand Reduction										0.1		0.1
				Law Enforcement									0.3	0.2		0.4
				Total	**5.5**	**4.2**	**4.7**	**4.6**	**5.4**	**4.6**	**6.8**	**10.6**	**13.2**	**11.2**	**10.3**	**11.4**
		United Arab Emirates														
			DHS ICE													
				Law Enforcement									0.0	0.0	0.0	0.0
			DOJ DEA													
				Intelligence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	0.1	0.1	0.1
				Law Enforcement	0.0	0.0	0.0	0.0	0.0	0.0	0.4	2.1	2.4	2.5	2.8	3.0
				Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.5**	**2.2**	**2.6**	**2.7**	**3.0**	**3.1**
		Uzbekistan														
			DOJ DEA													
				Intelligence	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.1	0.1
				Law Enforcement	0.0	0.0	0.2	0.8	1.2	1.4	1.7	0.6	0.0	0.3	2.0	2.1
				Total	**0.0**	**0.0**	**0.2**	**0.8**	**1.3**	**1.4**	**1.8**	**0.6**	**0.0**	**0.3**	**2.1**	**2.2**
	Worldwide															
		Air Bridge Denial Program														
			State INL													
				Other						11.1	13.9					
				Total						**11.1**	**13.9**					

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Worldwide															
		Critical Flight Safety Program														
			State INL													
				Other							30.0	61.0				
				Eradication											8.0	6.2
				Other											7.3	5.6
				Total							**30.0**	**61.0**			**15.4**	**11.8**
		Demand Reduction														
			State INL													
				Demand Reduction	3.9	4.5	5.0	5.0	4.2	9.9	9.9	8.0	11.9	10.0	14.0	12.5
				Total	**3.9**	**4.5**	**5.0**	**5.0**	**4.2**	**9.9**	**9.9**	**8.0**	**11.9**	**10.0**	**14.0**	**12.5**
		International Organizations														
			State INL													
				Other	12.0	12.0	16.0	2.9	13.0	5.0	4.0	4.1	3.0	4.0	3.9	3.9
				Total	**12.0**	**12.0**	**16.0**	**2.9**	**13.0**	**5.0**	**4.0**	**4.1**	**3.0**	**4.0**	**3.9**	**3.9**
		Interregional Aviation Support														
			State INL													
				Eradication	48.4	48.4	52.8	57.1	61.4	58.0	55.8	55.6	47.2	45.1	48.3	48.9
				Other	1.6	1.6	7.2	7.9	8.6	8.6	7.1	7.4	7.5	7.4	11.4	11.4
				Total	**50.0**	**50.0**	**60.0**	**65.0**	**70.0**	**66.6**	**62.9**	**63.0**	**54.7**	**52.4**	**59.7**	**60.4**
		Program Development and Support														
			State INL													
				Other	9.8	12.2	13.0	13.9	13.9	13.9	11.0	13.3	12.2	15.4	12.0	12.0
				Total	**9.8**	**12.2**	**13.0**	**13.9**	**13.9**	**13.9**	**11.0**	**13.3**	**12.2**	**15.4**	**12.0**	**12.0**

Function	Region	Nation/Region	Dept	Program/Activity	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
International																
	Worldwide															
		Regional Narcotics Training														
			State INL													
				Training/Equipping	5.1	5.5	5.0	4.5								
				Total	**5.1**	**5.5**	**5.0**	**4.5**								
		Systems Support/Upgrades														
			State INL													
				Other	5.0	4.0	6.0	4.0	5.0	0.7						
				Total	**5.0**	**4.0**	**6.0**	**4.0**	**5.0**	**0.7**						

National Drug Control Funding: Interdiction and International by Region/Nation (Defense) (in Millions)

Region	Country	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Africa													
	Africa/Europe Region	1.9	1.9	2.0	2.1	2.4	2.5	5.4	6.3	9.6	12.0	13.2	14.9
	Algeria	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.0	0.0	0.0	0.0
	Benin	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Burkina Faso	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Cameroon	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.8	0.8
	Cape Verde	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.4	0.0	0.2	0.3	0.3
	Cote Divoire	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Djibouti	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
	Egypt	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
	Gabon	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
	Gambia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
	Ghana	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.7	0.6	0.5	5.2
	Guinea	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3	0.3
	Guinea-Bissau	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.9
	Kenya	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.1	0.1
	Liberia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.5	1.3
	Libya	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Madagascar	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Mali	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Mauritania	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.3	0.9	0.9	0.9
	Mauritius	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Morocco	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.4	0.4
	Mozambique	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0
	Niger	0.0	0.0	0.0	0.0	0.0	1.9	0.3	0.0	0.0	0.0	0.0	0.0

Region	Country	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Africa													
	Nigeria	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.5	2.6
	Rwanda	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
	Sao tome	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.1	0.1
	Senegal	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	1.0	1.6
	Seychelles	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Sierra Leone	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.8	0.8
	South africa	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
	Tanzania	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
	Tunisia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.8	0.8
	Zambia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Caribbean													
	Aruba	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Bahamas	1.8	1.8	1.4	1.2	1.4	1.5	4.7	6.4	12.6	9.9	11.8	10.0
	Barbados	0.3	0.7	0.4	0.4	0.4	0.2	0.2	0.1	0.1	0.2	0.2	0.2
	Caribbean Region	100.3	98.6	83.7	73.6	68.5	53.1	58.9	114.2	115.7	154.9	139.6	104.0
	Cayman Islands	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Dominican Republic	0.7	0.6	0.4	0.8	0.8	0.9	0.7	0.8	1.0	1.1	3.7	7.1
	Haiti	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
	Jamaica	0.4	0.5	0.4	0.4	0.5	1.4	0.6	0.5	0.6	0.8	1.7	3.1
	Martinique	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Netherlands Antilles	8.8	8.3	9.8	13.0	15.1	16.7	16.3	18.5	19.5	25.6	28.3	21.2
	Puerto Rico	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	0.1	0.1	0.1	0.1
	Trinidad and Tobago	0.6	0.3	0.3	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.4	3.1
Central America													
	Belize	0.1	0.4	0.4	0.3	0.3	0.2	0.3	1.9	0.9	1.4	2.5	5.3
	Costa Rica	0.8	1.0	0.9	1.2	1.1	0.7	0.6	0.8	2.5	0.8	2.7	3.4
	El Salvador	3.8	6.8	4.0	5.6	5.9	6.6	6.1	1.1	1.0	1.5	2.8	4.6
	Guatemala	0.6	1.1	0.7	0.8	0.8	0.7	1.4	1.9	2.5	2.5	4.4	6.5

Region	Country	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Central America													
	Honduras	0.2	0.7	1.0	1.0	1.0	0.6	0.6	1.1	3.6	3.8	3.0	5.3
	Latin American Region	117.7	141.0	112.1	104.0	101.3	142.4	107.0	61.7	71.0	78.6	70.4	117.6
	Nicaragua	0.0	0.2	0.2	0.2	0.2	0.5	0.5	3.0	2.7	5.0	2.7	3.7
	Panama	1.1	1.3	1.4	2.6	1.6	0.9	0.9	2.4	3.6	2.6	4.3	5.2
Central Asia													
	Central Asia Region	0.0	0.0	0.0	0.4	0.5	0.7	2.8	3.6	1.2	1.2	1.2	2.1
Europe													
	Albania	0.0	0.0	0.0	0.0	0.0	0.3	0.1	0.0	0.0	1.1	0.7	1.1
	Belgium	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
	Bosnia and Herzegovia	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.5	0.7
	Bulgaria	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	0.1
	Croatia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	0.8
	Cyprus	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Estonia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.1	0.1
	Europe Region	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.7	1.8	1.9	1.5
	France	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Georgia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.6	0.1	0.0
	Germany	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.1	0.1
	Greece	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.2	0.0
	Italy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3	1.0	1.5
	Latvia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
	Lithuania	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
	Macedonia	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.6	0.0	0.1	0.2	0.4
	Malta	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	0.6	0.2	0.3
	Moldova	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
	Netherlands	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.1	0.1	0.1
	Portugal	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.4	0.4	0.9	1.8
	Romania	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.9	0.1	0.1	0.1

Region	Country	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Europe													
	Russia	0.0	0.0	0.3	0.4	0.4	0.5	0.2	0.3	0.2	0.2	0.2	0.2
	Serbia and Montenegro	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.1	0.4
	Slovenia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.4
	Spain	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.5
	Ukraine	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	1.4	0.2	0.2
	United Kingdom	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0
North America													
	Canada	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Mexico	17.7	18.1	14.8	13.7	10.5	9.7	15.2	15.5	12.2	34.2	86.2	69.6
South America													
	Argentina	0.0	0.3	0.3	0.2	0.3	0.2	0.2	0.2	0.4	0.5	0.6	0.6
	Bolivia	5.9	4.5	4.9	3.9	4.0	5.6	3.9	2.0	1.4	0.4	2.3	3.0
	Brazil	0.3	0.8	0.7	0.8	0.8	0.6	1.0	0.7	2.0	0.7	2.7	2.2
	Chile	0.0	0.2	0.2	0.2	0.7	0.4	0.2	0.1	0.2	0.5	0.5	0.5
	Colombia	128.0	188.3	117.3	164.8	178.2	155.3	140.5	129.4	119.9	127.9	122.8	113.5
	Ecuador	32.8	33.1	41.1	18.9	18.8	21.1	23.8	21.8	20.4	20.1	13.4	14.2
	Paraguay	0.1	0.3	0.3	0.5	1.1	0.5	1.2	1.6	2.4	1.3	1.8	1.8
	Peru	10.6	10.4	11.1	6.3	7.1	7.3	11.9	8.0	8.4	8.9	16.8	13.4
	Suriname	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.3	0.3	0.3
	Uruguay	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.3	0.3
	Venezuela	6.2	6.9	6.2	5.5	1.0	0.8	0.5	0.5	0.5	0.5	0.6	0.6
Southeast Asia													
	Australia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.2
	Brunei Darussalam	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Burma	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0
	Cambodia	0.0	0.0	0.0	0.0	0.0	0.3	0.7	0.2	0.7	1.5	0.9	0.8
	China	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.2	0.2	0.2
	Guam	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0

Region	Country	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Southeast Asia													
	India	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2	0.4
	Indonesia	0.0	0.0	0.0	0.0	0.0	1.1	3.4	0.4	1.6	2.7	3.4	2.3
	Japan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Malaysia	0.1	0.3	0.3	0.3	0.6	0.2	2.0	0.7	0.8	1.1	0.7	1.1
	Micronesia-Federated States	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Philippines	0.0	0.0	0.0	0.0	0.4	1.3	4.8	1.0	3.0	2.9	2.3	2.4
	Southeast Asia Region	8.4	9.2	8.0	8.8	7.9	22.4	7.7	21.0	23.4	24.5	30.4	32.0
	Thailand	2.4	3.5	4.8	5.9	3.4	3.0	4.7	2.7	3.0	4.1	3.0	3.5
	Togo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
	Vietnam	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.3	0.8	0.0	0.3
Southwest Asia													
	Afghanistan	0.0	0.0	0.2	0.2	90.8	219.0	76.7	240.1	204.1	262.5	327.4	51.0
	Azerbaijan	0.0	0.0	0.0	0.0	0.0	1.5	2.3	0.6	0.1	0.0	0.1	0.0
	Jordan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Kazakhstan	0.0	0.0	0.0	0.0	0.0	0.0	0.5	11.7	0.7	7.4	7.2	0.6
	Kyrgyzstan	0.0	0.0	0.0	0.0	0.0	5.3	5.4	13.1	25.1	4.3	22.4	0.0
	Oman	0.0	0.1	0.1	0.1	0.1	4.2	3.3	0.0	0.0	0.0	0.0	0.0
	Pakistan	0.0	0.0	0.4	0.0	1.2	9.2	14.3	37.1	71.8	25.2	42.9	0.4
	Southwest Asia Region	2.1	1.5	1.7	3.3	3.3	11.7	12.3	21.5	24.0	28.1	30.6	26.6
	Tajikistan	0.0	0.0	0.0	0.5	0.0	9.6	5.8	6.2	25.3	1.3	19.9	0.0
	Turkey	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.4
	Turkmenistan	0.0	0.0	0.0	0.0	0.0	4.9	0.0	4.0	9.5	0.9	7.7	0.0
	United Arab Emirates	0.2	0.1	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Uzbekistan	0.0	0.2	0.2	6.6	0.6	0.0	0.0	0.0	0.0	0.0	4.0	0.0
	Yemen	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.7	0.0